



DOCTOR OF HEALTH (DHEALTH)

The leadership experience: a qualitative study exploring the perceptions of middle managers in an acute healthcare setting

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Award date:
2017

Awarding institution:
University of Bath

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**The leadership experience:
a qualitative study exploring the perceptions of middle
managers in an acute healthcare setting**

Vanya Aquilina

A thesis submitted for the degree of Professional Doctorate in Health

University of Bath
School for Health

July 2016

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Acknowledgements

I would like to express my heartfelt thanks to my supervisors, Dr Zeynep Yalabik and Dr Maria Cassar, for their motivation, incisive comments and suggestions in the preparation of this thesis.

My sincere appreciation to Dr David Wainwright, Director of Studies for the Professional Doctorate in Health programmes, for his generous guidance throughout the programme.

I wish to acknowledge the support provided by the tutors and peers, and Peter Bradley, subject librarian at the University of Bath.

Thanks are due to the Malta Government Scholarship Scheme. This doctoral study was carried out using funds awarded by the Scholarship Scheme grant.

I also want to thank the study participants for their cooperation and generosity of time. I am deeply indebted to them for sharing their experiences with me, and from whom I learnt so much.

A special gratitude goes to my parents and family for believing in me and for their patience, encouragement and support in the good and bad times throughout the stages of the programme.

I am very grateful to friends who inspired me to keep moving forward in spite of challenges.

And finally, thank God for giving me the courage, determination and perseverance to endure this academic journey.

Abstract

Competing tensions are known to be experienced by middle managers in healthcare settings. The increased complexity and higher dynamic nature in acute healthcare contexts increase the demands expected of middle managers. There is limited research focusing on the leadership experience of nurse and allied health middle managers working within acute healthcare contexts. In view of this gap, the aim of this study is to explore the leadership perceptions of nurse and allied health middle managers. Their perceptions of the impact of leadership training and professional development practices are also explored. The Competing Values Framework provides a useful framework for gaining insight into the leadership experience of middle managers. The principal research question is: What is the leadership experience of nurse and allied health middle managers in an acute public general hospital?

A qualitative approach using semi-structured interviews was held with nurse and allied health middle managers working within the main acute public general hospital in Malta. Through purposive sampling, 21 middle managers consented to participate in the study. Thematic analysis was conducted identifying codes and themes within the data, from which findings were derived.

Findings suggest that nurse and allied health middle managers fulfil contradictory and competing demands within dynamic healthcare contexts, underlining the intense emotions experienced by them, and their struggle to achieve a balance across conflicting situations. Middle managers suggested that they would benefit from communities of practice development approaches and mentoring programmes, to help them cope with workplace demands and the contradictions within their role. A central recommendation of this study is the inclusion of middle managers in planning future leadership training and development programmes. This may be effected through a partnership approach with senior managers and trainers so that training significantly contributes towards enabling optimal performance of middle managers, and the ultimate improvement of patient safety and quality healthcare. This research has implications as to where and how resources for developing middle managers should be invested in acute healthcare contexts.

Abbreviations and acronyms

CAQDAS Computer Assisted Qualitative Data Analysis Software

CEO Chief Executive Officer

CVF Competing Values Framework

EU European Union

HROs High Reliability Organisations

MDH Mater Dei Hospital

MFH Ministry for Health

NHS National Health Service

REACH Research Ethics Approval Committee for Health

UK United Kingdom

UREC University of Malta Research Ethics Committee

US United States

Definition of terms

For the purposes of this study, the following terms will carry the respective meanings noted below:

Allied health professions: these are a wide variety of professions providing a range of diagnostic, technical, therapeutic and direct patient care and support services that are critical to quality patient care. They are a “distinct group of health professionals who apply their expertise to prevent disease transmission, diagnose, treat and rehabilitate people of all ages and all specialities. Together with a range of technical and support staff, they may deliver direct patient care, rehabilitation, treatment, diagnostics, and health improvement interventions to restore and maintain optimal physical, sensory, psychological, cognitive, and social functions” (International Chief Health Professions Officers 2012, cited by Patel et al. 2015).

Allied health professions vary greatly in terms of the work they do. The educational process and training of allied health professions also varies. However, all allied health care services fall under the responsibility of the allied health care services directorate. The directorate captures the diversity of allied health professions and makes policy decisions affecting allied health practitioners in the healthcare system.

Competencies: in the complex world of health sciences competencies go beyond knowledge, skills and behaviour. They involve “other qualities such as attitudes, motives, personal insightfulness, interpretive ability, receptivity, maturity, and self-assessment” (Axley 2008, p.218). These qualities translate knowledge into action, and are crucial to middle managers’ and the organisation’s performance.

Competing Values Framework (CVF): a framework of leadership developed by Quinn (1988). It is a means of characterising individual and organisational leadership, and addresses issues of contradiction and paradox. The CVF represents the conflicting demands of managerial leadership, allowing individuals to move away from an either/or approach, and take account of opposite positive values (Cameron et al. 2006). It implies that managers with broad leadership abilities that include complexity, contradiction and paradox will be the most effective (Denison et al. 1995).

Complexity: Denison et al. (1995) defined complexity as “the ability to respond to a host of ambiguous and contradictory forces, including the simultaneous presence of opposites” (p.526). It is directly linked to paradox and contradiction. Complexity is “commonly utilized in health

care literature to explain the unpredictable nature of behaviors and interactions occurring in the health care systems” (Stringer 2014, p.22).

Complex organisations: a school of thought on complex organisations, such as healthcare organisations, is that extremely safe operations are possible, even with extremely hazardous technology. These are what are then called **high reliability organisations (HROs)**, namely “organisations that are able to manage and sustain almost error-free performance despite operating in hazardous conditions where the consequences of errors could be catastrophic” (Lekka 2011, p.v). This is done in an environment in which “all workers look for, and report, small problems or unsafe conditions before they pose a substantial risk to the organization and when they are easy to fix” (Chassin and Loeb 2013, p.461).

Emotion: there is no widely agreed upon definition of emotion. For Game (1997) emotion is a way of knowing the world, and emotions are the means by which we make sense of, and relate to, our physical, natural and social world. Stringer (2014) observed that emotional competence is a valuable component of effective leadership in healthcare leaders.

Healthcare: the World Health Organization (2007) defined healthcare as a system consisting of people and organisations whose goal is to provide, improve and promote the health of all people through various entities.

Leadership: in a healthcare context leadership is a “way of thinking and a way of behaving...about effecting change and enabling others to think and behave differently in order to bring about positive improvements in the experience of patients and service users, through redesigning the current systems of care that are offered” (Pond 2006, p.100). Hence, leadership is associated with “the effective and efficient resolution of problems” (Grint 2005, p.1478). For the purpose of this thesis, I will borrow Pond’s (2006) definition of leadership as it describes accurately the complexity of leadership of nurse and allied health middle managers working within healthcare. Moreover, inherent in the definition is the power of leadership to influence, motivate, enable and inspire others to achieve personal or organisational goals in meaningful ways.

Leadership experience: this is the nurse and allied health middle managers’ very own experience of practising leadership. These health professionals experience leadership by doing, being and feeling. They gain understanding, meaning, skills and knowledge based on their direct participation in leadership activities. McEwen and Wills (2002, p.17) suggested that experience is constructed through the individual’s unique occurrences of events lived through

and the “patterns of meaning and values.” Experience is also “shaped by emotions, desire, perception and interest” (Gabriel 2004b, p.170).

In this study, the characteristics of the leadership experience were presented and defined by middle managers in their own words. They provided their own perceptions, insights and understanding into the practical implications of leadership, inherent in addressing their challenges, concerns and emotions within their everyday organisational realities, and their leadership development and training needs. Exploring and understanding the leadership experience involved an understanding of the middle managers’ experience of leadership reality within the setting of Mater Dei Hospital (MDH).

Mater Dei Hospital (MDH): this is the principal acute public general hospital in Malta, providing a full range of services including secondary and tertiary care. The hospital provides an inpatient service and a number of outpatient services. MDH is financed from general taxation and is free at the point of use. MDH aims to create a centre of excellence in the provision of effective and efficient, acute patient-centred quality care. It also aims to achieve high levels of patient and staff satisfaction, and enhance teaching, research and innovation (Government of Malta 2015).

In addition to the provision of patient care, MDH is also a teaching hospital, that is, it teaches undergraduate medical, dental and pharmacy students, nursing students and allied health students. A Postgraduate Medical Training Centre is also present at MDH. This centre caters for postgraduate medical training and professional support in collaboration with Medical Specialist Colleges and Associations.

The purpose of this research study was to explore the experience of leadership of healthcare middle managers in a specific context. The term ‘context’ is multifaceted in nature. For this study, ‘context’ is the particular acute healthcare setting of MDH, the environment in which the research participants, that is, the nurse and allied health middle managers were operating in.

Middle managers: the definition of middle managers in this study focuses on those working in a health services context, and who plan and coordinate services pertaining to their units (Currie 2006).

For the purpose of this thesis, middle managers within the local healthcare context are the nurse and allied health workers with a professional qualification and a clinical background, who are more aligned to management and leadership rather than the highly clinical and specialised professional fields they represent (Micallef 2011). The middle managers participating in this

research were the professional lead allied health practitioners and advanced allied health practitioners drawn from the allied health professions, and the chief nursing manager and senior nursing managers drawn from the nursing profession. Their job descriptions are found in Appendix I. After completing their formal professional education, healthcare middle managers furthered their knowledge and skills in management and leadership, and obtained a number of certifications in leadership and management.

When field work was initiated, the chief nursing manager and senior nursing managers were known as the manager, nursing services and departmental nursing managers respectively; the professional lead allied health practitioners and advanced allied health practitioners were known as the managers and senior principals of their respective professions.

Narratives and stories: narratives require sequencing and involve inter-related events or actions, undertaken by characters (Gabriel 2004b). Sims (2003, p.1197) defined stories as “narratives with a sense of plot. The plot may be of many different kinds, but essentially the plot is how the person makes sense of the story in which they are placing themselves.” In this study middle managers used story-telling to interpret their world. Story-telling gave them a voice that allowed them to articulate their leadership experience, and to reveal the meanings that they constructed around their leadership realities. Indeed, story-telling is “a valid means for producing and accumulating knowledge” (Hummel 1991, p.31).

Organisational culture: this is concerned “with the *meaning* that people invest in organizations, organizational structures, memorable events, noteworthy people, processes and procedures. This ‘meaning’ provides a set of core beliefs or values each individual holds about their organization...culture is often difficult for employees to articulate as it is concerned with deeply held assumptions, often based on a long-term relationship with their organization” (Grant et al. 2006).

Paradoxical leadership: a paradox perspective involves “contradictory yet interrelated elements that exist simultaneously and persist over time” (Smith and Lewis 2011, p.382). Hence, paradoxical leadership highlights the tensions, contradictions and paradoxes inherent in organisations and their leaders (Lavine 2014).

Patient-centred care: this is the provision of “care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions” (Institute of Medicine 2001, p.3).

Perception: is our version of reality. The process of perception “leads to a continuous adaptation of knowledge which undergoes constant growth, transformation and extension.

Knowledge is therefore not something rigid or fixed that accumulated indefinitely in a steady way but is a continual process of change” (Bohm and David Peat 1991, p.31). The process of perception explored the beliefs, attitudes and assumptions of nurse and allied health middle managers participating in this study, and this enacted their leadership reality. Indeed, perceptual abilities allowed participants to make sense of, and interpret their leadership experience (Eysenck 2002). Through perception, concepts were formed that organised and interpreted unfamiliar information.

Role: Sarbin and Allen (1968, cited by Mintzberg 1973) defined a role as “an organized set of behaviors belonging to an identifiable office or position.” Therefore “actors, managers, and others play roles that are predetermined, although individuals may interpret them in different ways” (p.54). In this study, the roles of nurse and allied health middle managers contributed to their leadership experience.

Support: “is the degree to which there is a sense of warmth” and through which individuals feel “that they are ‘backed up’ by others” (Nicolson et al. 2010, p.57). Support determines the amount of trust and respect amongst employees.

Secondary health care: acute healthcare provided at MDH concerned with the provision of specific technical, therapeutic or diagnostic services. This can be either emergency care or elective care. These services are episodic and usually focused on a particular health problem.

Tacit knowledge: Michael Polanyi formulated the concept of tacit knowledge in 1958. Tacit knowledge is personal and context specific, and resides within the individual nurse and allied health middle managers. Tacit knowledge includes insights and intuitions, and is ever-changing with the experience of the healthcare middle managers, through introspection, reflection and consciousness (Turner 2012).

Tertiary health care: this is the specialist care provided at MDH. The hospital provides complex medical and surgical interventions, including transplant surgery and open heart surgery.

Triangulation: refers to the use of various methods and sources, such as data, method, time, person and site, for collecting and analysing data about the phenomenon being studied. The purpose of triangulation is to seek confirmation for completeness of findings (Fenech Adami and Kiger 2005). In this study, triangulation of data methods was used as an additional strategy to support a more in-depth understanding of findings. Field notes and reflexivity provided a more comprehensive insight of the area being explored.

Chapter 1 Introduction

1.1 Thesis motivation

The focus of this research study stemmed from my interest in leadership and the behavioural dynamics involved in leadership through my role as a middle manager in physiotherapy, working within an acute healthcare setting. I have held such a managerial role for 13 years. Through my own personal experience, and also, through communication with other members of the healthcare team, I became increasingly aware of the competing demands and roles expected of middle managers working within the context of an acute public general hospital. In parallel, I became conscious that with the increasing challenges and the pace of change facing the health service, it is imperative that middle managers have the leadership capability to drive the healthcare service. This personal experience and observations stimulated the development of the research study reported in this thesis. Upon searching and reviewing the literature, I found that previous research in this field was limited and sparse. Successively, I got intrigued in exploring the leadership experience of healthcare middle managers hailing from the nursing and allied health professions. This is one area which this thesis will address.

I developed my research idea further when as a middle manager I was invited to attend the leadership and management internal training course provided by my employer, the Ministry for Health (MFH), within the government of Malta. This was a short course for healthcare managers, focusing on leadership and management skills and values. During the training programme, I was struck and impressed by the leadership experience recounted by the course participants. I realised that although leadership experience may be shared, it is indeed “the individual who is ultimately the one who interprets the experience and gives meaning to it” (Munhall 1989, p.22). I was led to believe that unique perceptions enrich the authenticity of an individual’s experience. The accounts related by individual managers pursuing the course heightened my interest in exploring middle managers’ experience of leadership, when such managers hail from the nursing or allied health professions, rather than from a managerial education background and work experience.

Therefore, I wished to listen to middle managers’ voices, investigate and seek to understand their everyday leadership thoughts and perceptions from their perspective, as experienced within the specific context of the health entity in which they worked at, in Malta. I was prompted to explore their experience in the context of the experience of leadership of managers in other settings, and of managers from other work and education backgrounds. I was curious about the originality and uniqueness, or otherwise, of middle managers in the context of this research study, in view of how and where it fits in the wider context. Moreover, I believed that gaining

such understanding regarding all this may contribute towards enabling an enhanced experience of leadership for middle managers in the healthcare context.

1.2 Significance and statement of the problem

Denis et al. (2010) described leadership as a dynamic phenomenon, “a process that evolves over time in context” (p.72). Furthermore, Dye (2000) explained that healthcare organisations have grown into complex and unpredictable environments, with healthcare leaders experiencing a number of challenges, and high levels of pressure and anxiety, mostly caused by the complexity of healthcare changes. Certainly, health care organisations may be referred to as high reliability organisations (HROs). In her review of the literature on HROs, Lekka (2011) in fact acknowledged the importance of leadership in implementing and sustaining HRO processes. Specifically in the context of leadership, with specific respect to hospitals and health systems, Chassin and Loeb (2013) further reported that HROs are acquired through “the leadership's commitment to achieving zero patient harm, a fully functional culture of safety throughout the organization, and the widespread deployment of highly effective process improvement tools” (pp.459-460). Hence, leadership commitment to high reliability is a key factor in enhancing safety and quality in healthcare.

Indeed, healthcare leaders face pressures and experience a shift along a continuum varying from autocracy to democracy, from stability to flexibility, from controlling to facilitating, thus reflecting the diverse demands and responsibilities required for leading complex organisations (Daft 2015). This is crucial for patient safety and quality healthcare. Such a stance is reflected in the contradictory and complimentary leadership roles illustrated by the Competing Values Framework (CVF). The CVF was used as the conceptual framework to position this research study. It reflects the “contradictory criteria of effectiveness that describe managerial leadership” (Viitanen and Konu 2009, p.110) and uncovers the complexities of middle managers’ leadership experience. Besides, hospitals are often described as contexts rich in anxieties, constantly under public scrutiny, “increasingly faced with the prospect of public censure or litigation”, “financial cuts” and their “ability to maintain standards” (Lökmán et al. 2011, p.30). These shape the hospital’s norms, values and expectations that in turn influence the healthcare system, its managerial roles and leadership realities (Suddaby et al. 2010). Accordingly, it is particularly relevant that healthcare organisations such as hospitals ensure that healthcare leaders are skilled and competent through continuous development and training (Stringer 2014).

Although previous research has suggested that the responsibilities of nurse and allied health middle managers include leading complex organisations, literature focused on the leadership experience of hospital middle managers is limited. The principal research question was: What is the leadership experience of nurse and allied health middle managers working in an acute public

general hospital? Thus, it was the aim of my thesis to provide understanding and knowledge into nurse and allied health middle managers' own experience of practising leadership within the setting of a principal acute general hospital. This is inherent in middle managers' perceptions of their challenges, concerns and feelings, as well as their perceived experiences of leadership development needs, reflected through their experiences of training and learning.

This qualitative study contributes to knowledge by exploring, describing and interpreting middle managers' leadership perceptions, and their perceived leadership training and development needs. By clarifying these challenges, concerns and motivations, this study revealed insights into the leadership training and development of middle managers which may address professional practice issues. Moreover, the study applied and adapted existing knowledge, and embedded this within a professional practice context. Presently there is a gap in the literature, and the leadership experience of nurse and allied health middle managers has yet to be documented. The study findings and conclusions will provide recommendations to support and improve healthcare middle managers in their roles. The study will also produce valuable information to develop the leadership experience of middle managers and improve health practice by ensuring the provision of safe, effective and efficient, patient-centred quality care and delivery.

1.3 Research questions

This was an exploratory qualitative study designed to answer the following research questions:

1. What are the leadership perceptions of nurse and allied health middle managers in an acute public general hospital?
2. How do these middle managers describe the challenges that impacted on their abilities to lead within their organisation?
3. How can healthcare middle managers be better supported in their leadership training and development needs?

1.4 The context – the research setting

Malta has been providing public funded healthcare services for a very long time. The development of hospitals was among the first projects to be undertaken by the Knights of St John during their rule in Malta in the 14th century. The healthcare system in Malta is predominantly tax-funded, with the health expenditure coming mainly from government sources. Presently, the Maltese government provides comprehensive healthcare services that are free at the point of delivery for all Maltese residents. Entitlements to a number of services however, such as elective dental care are means tested. Foreigners who have moved to Malta are also entitled to public healthcare (Azzopardi et al. 2014).

This study took place within Mater Dei Hospital (MDH), the main acute general hospital in the Mediterranean island of Malta, located on the periphery of the European Union (EU). It is pertinent to highlight that as an EU member state, Malta is obliged to follow EU directives, in particular in regard to the Health Professions Act in regulating healthcare professionals, as well as the macro-economic and financial obligations stated in the European Semester. The European Semester is the EU's annual cycle of economic policy guidance and surveillance (European Commission 2016).

MDH is one of the largest medical buildings in Europe. The opening of this new hospital in 2007 represented a vision of excellence, “signifying a quality leap in the environment within which care is delivered” (Ministry for Finance 2006). Besides the emphasis on leadership at all levels, MDH places a focus on clinical leadership to ensure successful healthcare delivery by addressing the needs of staff and patients through good quality, and efficient and effective services (Micallef 2011). A healthy population is a basic requirement for national competitiveness and economic development. Driven by its 2015 Vision (Office of the Prime Minister 2011) to set up the health sector as one of the major pillars of socio-economic development, the Maltese government decided to give heightened consideration to quality of care and patient safety. MDH welcomed this government initiative. Subsequently, members of the top management team of MDH identified quality healthcare and safety to be key to the Maltese health service (Caruana 2011).

MDH caters for all medical specialities, amongst which are Medicine, Surgery, Orthopaedics, Cardiac Services, Ophthalmology, Dentistry, Paediatrics, Neuroscience and Obstetrics and Gynaecology. The hospital provides secondary and tertiary care, including specific technical, therapeutic and diagnostic services, of emergency or elective nature (Azzopardi et al. 2014). Patients are admitted to MDH either through the emergency department or through a referral by their doctor. During the time data were being collated for the study, MDH had 827 inpatient beds, around 100 day care beds and a staff population of 4400, consisting of health professionals, administrative staff and support staff (N. Cuschieri, pers.comm., 7 May 2012). The hospital caters for a local national population of 417432, as recorded in the 2011 Census of Population and Housing (National Statistics Office 2014).

Nurses and allied health professionals form 2 of the largest groups of healthcare professionals, underlining the importance of their roles as managers and leaders in healthcare organisations (Azzopardi et al. 2014). Middle managers often function within a context of complex and contradictory expectations, having to continually deal with various situations requiring planning, negotiating and decision-making (Sims 2003). Being the link between senior management and clinicians, healthcare managers in the middle management level assume roles

that bridge organisational and professional roles (Anthony et al. 2005). “Middle managers have also been identified as key agents, leading change ‘quietly’ and ‘below the radar’, as ‘ideas practitioners’, as well as implementing, synthesising, championing and facilitating strategic organizational change” (Buchanan et al. 2013, p.43). Hence, nurse and allied health middle managers experience complex and ambiguous positions, with their position rendered even more complex within a professional bureaucracy, such as a healthcare organisation (Currie and Procter 2005). Clearly, the role of nurse and allied health middle managers is pivotal in patient safety and quality of care.

Nonetheless, high levels of demotivation, dissatisfaction, apathy and lack of engagement existed amongst nurse and allied health managers within the local health service (Micallef 2011). These were blocking the potential and progress of these highly educated and specialised professional healthcare managers. Initial indications showed that problems were strongly linked to lack of skill, knowledge and experience within the fields of management and leadership (Micallef 2011). Such awareness developed against the observation that leaders in healthcare originate from professional ranks and their formal education very rarely includes management and leadership training (Contino 2004). Aware of these realities, MFH sought to actively address core challenges by focusing on a different way of working, simultaneously reinforcing a learning and continuous development culture. Subsequently, in 2006, leadership and management training programmes were rolled out to healthcare managers. These efforts were initiated because top management recognised that for the health sector to be financially viable, it required competent leaders and managers who carefully invested the resources available whilst realistically addressing total quality care and patient safety (Micallef 2011). The objective of this training was to assist healthcare managers in asserting their strategic leadership and management role in a changing environment, and to put into tangible practice and use their numerous skills and values linking them to better governance and organisational development.

1.5 Structure of the thesis

This thesis is divided into 5 chapters. In the introduction, I stated my research position, motivations and intentions. I also highlighted the originality of the research.

Chapter 2 positions the research within a theoretical context through the evaluation of relevant literature. So as to set a foundation for this research study, areas within the literature were reviewed. This includes a background to the CVP, which was used to guide data collection. Additionally, the literature review discusses the healthcare context, and middle managers’ leadership perceptions, as defined by their role, emotions and interpersonal relationships. Middle managers play critical roles within acute healthcare settings, and therefore must be able to address healthcare needs in a rapidly changing, complex environment. Leadership training

and development are essential for middle managers to deal with the demands of managerial leadership within a complex healthcare context. Therefore, leadership training and development, which in this study were characterised by middle managers' preparation for their role, effectiveness of training, and improving professional development and education practices, were also reviewed. The review identifies a gap in research.

In addition to describing the aim and objectives, and justifying the design of the study, chapter 3 defines and explains the theoretical approach, choice of methods, ethical considerations, study population and sample characteristics. I also discuss how reflexivity was employed throughout the study so as to refine the research process.

Chapter 4 presents the findings that are derived from the semi-structured interviews with the 21 nurse and allied health middle managers. Data extracts are used to support the analysis. Three themes are identified, from which 4 findings are derived.

Chapter 5 is the final chapter. The findings and interpretation of the study are discussed in relation to existing literature on the leadership experience of healthcare middle managers. It sums up the thesis, restates the original contribution to knowledge, the significance of the research, and the limitations of the study. The main conclusions, with implications and recommendations for practice and future research are also presented.

Chapter 2 Literature review

2.1 Introduction

The purpose of the literature search was to identify previous related literature that would explain nurse and allied health middle managers' leadership perceptions, and their insights of training and leadership development needs in an acute healthcare setting. Quinn's (1988) model of leadership, based on Quinn and Rohrbaugh's (1983) CVF was selected as the framework to inform this research study. The CVF guided the theoretical and methodological bases for the development of the interview questions for this research.

Furthermore, the research study was built on 3 key interrelated concepts of literature exploring the research of related topics, namely, healthcare context, middle managers' leadership perceptions, and middle managers' training and leadership development needs. These 3 concepts provided an understanding into nurse and allied health middle managers' challenges in an acute healthcare context. The remainder of this chapter includes the conceptual framework of the study and an in-depth discussion on related literature. A brief overview of the 3 key concepts forming the theoretical model will be provided in this section.

The healthcare context is the first concept. It provides a brief overview of the healthcare organisation, and an understanding of the dynamics, complexity, challenges and the effect of leadership in healthcare organisations. The World Health Organization (2007) defined healthcare as a system consisting of people and organisations whose goal is to provide, improve and promote the health of all people through various entities. This definition of healthcare provides a common understanding and direction. It also gives insight into the leadership experience of healthcare middle managers who work in complex, dynamic and ambiguous settings (Denis et al.1996).

Three characteristics describe the second concept of nurse and allied health middle managers' leadership perceptions: middle managers' role, emotions and interpersonal relationships. These 3 characteristics focus on middle managers' emotions, challenges and concerns. They also provide examples of the complex activities occurring in the healthcare context at the middle management level.

The third concept is about middle managers' training and leadership development needs. In this study, these are reflected through middle managers' preparation for their role, effectiveness of training, and improving professional development practices. These attributes are important to

support middle managers in their dynamic and paradoxical roles, and to meet their leadership challenges in a rapidly changing and complex healthcare environment.

The literature review was based on a search of a number of online databases. The search was carried out to identify relevant peer-reviewed journal papers for inclusion in the thesis. The electronic databases included PubMed, Web of Knowledge, Web of Science and CINAHL, the cumulative index of nurse and allied health literature. These databases cover the field of the healthcare system, hence the decision for selection. A search was also conducted on Google Scholar for retrieval of grey literature, which includes materials such as reports, theses, conference proceedings, bibliographies and government reports and documents (Alberani et al. 1990). Search terms that were used included leadership, quality healthcare, hospital middle managers, middle manager relationships, complex organisations and their variants. The search was limited to papers published in the English language, with no limit imposed on the years of publication. Searches were also carried out within specific academic journals, such as Leadership Quarterly, Academy of Management Journal, Journal of Management, Journal of Leadership Studies, and Leadership and Organization Development so as to identify any relevant papers. Additional key material was identified through checking reference lists of relevant papers. Most of the retrieved articles were from the United Kingdom, United States, the Scandinavian countries and the Asia-Pacific region, but other studies conducted in Ireland, Portugal and Italy were also retrieved. There is a wealth of literature pertaining to leadership in general. However, there is lack of research on the leadership experience of nurse and allied health middle managers. The need for further research in this area, particularly from a local perspective is opportune.

2.2 Conceptual framework

The role of a conceptual framework is to provide a theoretical view of how relationships among several factors are important to the objectives of the research (Marshall et al. 2003; Strauss and Corbin 1994). It is founded on a theoretical model, guides study development and helps to focus data collection (Miles and Huberman 1994). Moreover, Polgar and Thomas (2008, p.249) advocated that a conceptual framework should be adopted for interpreting the understanding of research respondents' experiences.

Hence, synthesis of the literature reviewed established a theoretical model for situating this research study and for exploring the leadership experience of healthcare middle managers. This theoretical model was created on a foundation of 3 key interrelated concepts of literature, exploring topics related to the research. The theoretical model established the background for this study and set the foundation for understanding the leadership experience of healthcare

middle managers within an acute healthcare setting. It also attempted to connect all aspects of inquiry.

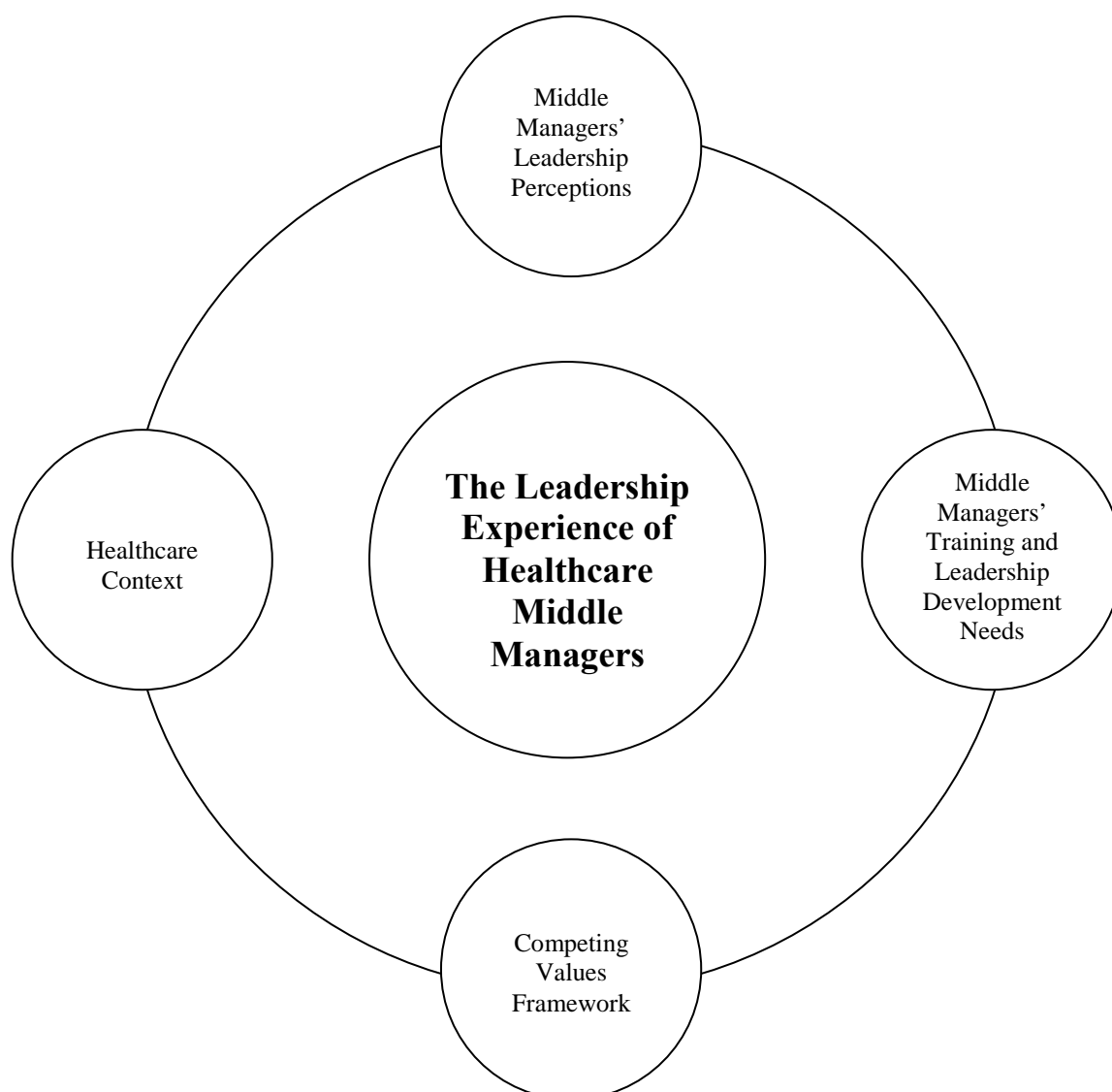


Figure 2.1: Theoretical model used to position the research study in relation to the literature. The model specifies the 3 key concepts involved in the research problem. The Competing Values Framework informed the research study.

The model in Figure 2.1 presents an overview of the 3 literature concepts providing insight and understanding of the leadership experience of healthcare middle managers. The concepts set the foundation for understanding the healthcare context and the challenges characterising the work of nurse and allied health middle managers, as well as the training and leadership development needs necessary to support and guide them in their developmental process. The CVF helped to inform and focus data collection.

2.3 Leadership theories

Various leadership theories have been used in healthcare. Some early theories assumed that leadership was genetically preordained. This led to the Great Man leadership theory. Other pivotal theories include the trait theory of leadership, which argues that there are certain generic

traits that can be identified in all effective leaders, followed by the behaviour approach. The behaviour approach pays more attention to how managers spend their time. On the contrary, situational theorists assert that effective leaders emerge as a result of a range of situational factors, namely, motivation, commitment and capability of followers. Other theorists emphasise on the manager's role in supporting subordinates. Furthermore, there are authentic leadership, which entails ethical and transparent behaviour, transactional leadership in which the primary purpose of subordinates is to do what the manager tells them, transformational leadership where leaders inspire followers to perform beyond expectations, and servant leadership, where the leader's primary motivation is to serve (Yukl 2010).

Healthcare organisations are complex in nature and effective leadership is necessary for the smooth functioning of an organisation. Considering leadership in healthcare, a combination of diverse leadership positions may be most efficacious for an organisation so that its leaders will be able to face paradox, contradiction and complexity (Melo et al. 2014; Hooijberg et al. 1997). Thus, it may be difficult to settle on a specific leadership theory. Indeed, as Yang and Shao (1996, p.524) affirmed, a “more complex and dynamic leadership theory that integrates contradictory and complementary leadership roles into one single model” may be more adequate to explore the perceptions of healthcare middle managers. These researchers were referring to the CVF. In fact, Melo et al. (2014, p.922) defined the CVF as “differentiated and privileged given the fact that it is based on leadership theories which include the performance of several roles”, and which address issues of contradiction and paradox. Hence, leaders may fulfil competing expectations and demands for high professional performance and provision of care. This is precisely why the CVF was selected to inform the research study. In fact, the characteristics of complexity, contradiction and paradox have been extracted from the CVF to underline the approach of the study.

2.4 The Competing Values Framework

The CVF originated from studies on the notion of effective organisational performance conducted by Robert Quinn and John Rohrbaugh in the late seventies and early eighties (Quinn 1988). It was later used to study various organisational research including culture, change and leadership effectiveness (Kalliath et al. 1999). In 1988, Quinn presented a leadership framework in terms of the competing values model of organisational effectiveness developed earlier. The leadership CVF is based on 2 positive tensions of effectiveness according to the level of control and focus: the tension between flexibility and stability; and the tension between the well-being and development of people within the organisation, and the well-being and development of the organisation itself (Figure 2.2).

When these value tensions are placed side by side, a spatial model emerges creating 4 quadrants of apparently competing values and conflicting but interrelated leadership characteristics (Quinn and Rohrbaugh 1983). Elizur (1984) defined work values as the importance individuals give to outcomes arising in the work context. From the CVF, a theory develops on how the various aspects of an organisation may function in simultaneous harmony and tension (Cameron et al. 2006). Nonetheless, the CVF does not imply that the 4 quadrants will receive equal emphasis by managers. Consequently, the CVF provides a definition of leadership that includes complexity, contradictions and paradox. It captures the dynamic and contradictory nature of the leadership experience, and also reflects the integration from balancing of competing demands and expectations within organisations (Lawrence et al. 2009). This characterises the rapidly changing world of health organisations (Melo et al. 2014). Hence, it has a major advantage in relation to other leadership theories in exploring the leadership perceptions of healthcare middle managers (Hooijberg et al. 1997).

The leadership concepts emanating from the CVF emphasise the simultaneous harmony and tension leaders experience in complex and dynamic organisations, such as healthcare. Literature posits that the role of middle managers is also complex and they need to respond to a wide range of competing demands and tensions (Berg and Huot 2007; Dubois et al. 2006). Middle managers therefore function within a context of complex, conflicting and contradictory expectations from peers, subordinates and superiors (Viitanen and Konu 2009), needing the ability to facilitate adaptation and change, and to persuade and influence (Melo et al. 2014). Hence, the CVF reflects the “contradictory criteria of effectiveness that describe managerial leadership” (Viitanen and Konu 2009, p.110). In fact, it pays particular attention to healthcare employees' perspectives, helping one make sense of the tensions individuals often experience in organisational life (Wicks and St. Claire 2007). Figure 2.2 depicts the leadership dimensions underlying the CVF. It graphically explains the paradox, complexity and contradictory characteristics describing middle management leadership in healthcare, and the simultaneous consideration and balance of the competing demands represented by each set of expectations (Morais and Graça 2013).

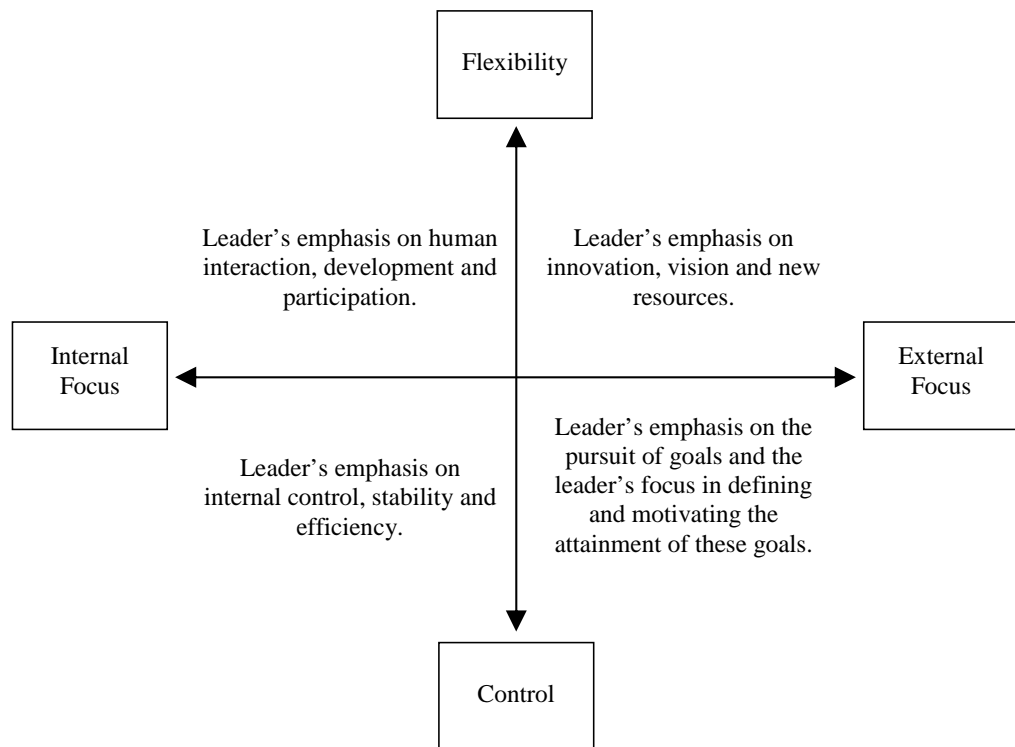


Figure 2.2: Leadership dimensions underlying the Competing Values Framework. The dimensions highlight the concepts of complexity, contradiction and paradox expected of managerial leaders and the competing demands represented by each set of expectations (based on the CVF model by Quinn 1988).

The CVF has been extensively tested, refined and rigorously validated, hence its robustness (Lavine 2014). In fact, scholars have used the CVF model in different organisational contexts and cultures, including complex and dynamic systems (O'Neill and Quinn 1993). It has also been widely used in health organisations research to help researchers make sense of the tensions people often experience in organisational life (Melo et al. 2014; Morais and Graça 2013; Helfrich et al. 2007). In this thesis, the CVF was not tested but was used to inform initial development of the research. This is in contrast to the study by Melo et al. (2014), in which a quantitative tool was used to measure the CVF and the 8 leadership roles played by manager nurses. In this thesis, a qualitative methodology was favoured with the use of the CVF because it elicited data that provided depth and detail to the leadership experience of healthcare middle managers (Bowen 2005). Furthermore, the CVF was used to focus data collection, as it clearly defines the conflicting demands of managerial leadership, and “highlights the contradictory nature inherent in organizational environments and the complexity of choices faced by managers when responding to competing tensions” (Belasen and Frank, 2008, p.128).

2.5 Concept one: healthcare context

To understand the experience of leadership of nurse and allied health middle managers in healthcare contexts, one must understand the factors influencing their healthcare environment. The first concept reviews the research and practice related to the healthcare setting, and the challenges and unpredictable factors inherent in such a setting.

Existing research in organisations in general revealed that organisations are often dynamic, and this dynamism of organisations is seldom translated into crisis situations (Osborn et al. 2002). These scholars described the environment of working in such a context as “the world of the edge of chaos” (p.822). In fact, the last years have seen great contrasts and changes in the overall shape of global economic activity. Following the banking crisis in the United States (US) in 2008, Europe was hit by one of the worst economic crisis in history. Subsequently, this crisis affected vulnerable populations in terms of health and health inequities, such as mental disorders and worsening access to healthcare services (De Vogli 2014). It is worth noting that whilst the economic crisis had a harmful public health effect in vulnerable groups, paradoxically, it also lead to favourable health effects in other socioeconomic groups, as long as there were strong social protection and low economic inequities (De Vogli 2014; Karanikolos et al. 2013). This means that the health sector throughout the world is continually going through rapid developments in response to both internal and external forces of change. Market dynamics have additionally created challenges for public organisations with the emergence of fixed budget constraints, advances in medical sciences, increased sophistication of advancing medical technologies, changes in work practices and greater patient education (Azzopardi Muscat et al. 2014). This has resulted in higher expectations and increased demands on health professionals, including middle managers.

Besides, the healthcare setting is often described as an impersonal (Lökman et al. 2011), unpredictable (Mickan and Boyce 2007; Downey-Ennis and Harrington 2002), high velocity environment (Pappas et al. 2004), and a “particularly ‘messy’ world in which multiple groups with different values, interests and expertise compete for influence” (Denis et al. 2010, p.68). Likewise, Rousseau (1995) used the layers of an onion to represent the organisational culture as a “system of interconnected layers of social experiences” (p.49). The “onion model of culture” (p.49) provides insight into the deeper, inner aspects of organisations, such as beliefs and feelings, vis-à-vis the more visible signs, such as behavioural and observational aspects. Anxiety, resistance and “tremendous upheaval” (p.50) result within the organisation when groups of employees within the healthcare setting do not share similar beliefs and values, that is, they do not share the same culture. Indeed, there may be more than one culture within an organisation and hence, the competing demands within organisations as underlined by the CVF.

Hackett and Spurgeon (1998) asserted that similar to healthcare settings in general, acute healthcare environments are “becoming increasingly messy, complicated and incoherent” (p.170). Consequently, acute healthcare contexts are characterised by complexity and change (Linton and Farrell 2009). For example, in her classic study exploring the high level of stress and anxiety amongst nurses in a general teaching hospital in London, Menzies (1960) stressed that a lot of hospital work involves a constant sense of impending crisis. Reinforcing this line of

reasoning, using a case-study approach of a large public hospital, Denis et al. (1996) examined the processes of leadership and organisational change. They suggested that acute healthcare contexts are ambiguous in terms of unclear goals, complicated hierarchy relations and difficulties in assessing outcomes. This in itself explains why leadership response is largely dependent on the setting in which it takes place (Hannah et al. 2009).

These trends pose significant challenges for innovative and progressive planning in healthcare systems. In their search for excellence, healthcare organisations including acute healthcare organisations, have attempted to become more patient-centred and responsive to these changes, through the provision of a more efficient and effective quality service (Downey-Ennis and Harrington 2002). In their paper, which focused on the Irish healthcare system, these scholars discerned the elements that offered healthcare institutions the opportunity to excel. They observed that in complex healthcare organisations, getting everyone engaged and committed was one of the biggest challenges in delivering excellence. The workforce was certainly key in delivering high quality care through a dynamic and responsive healthcare system.

Subsequently, healthcare managers are put under undue pressure to deliver effective and efficient services within the context of increasingly turbulent situations (Cartmill et al. 2012). In addition to providing a high quality service, managers must also “adopt a strong managerial perspective to improve performance in line with key organisational outcomes” (Mickan and Boyce 2007, p.175). Some leaders find these rapid changes and complexities perplexing. (Downey-Ennis and Harrington 2002). Effective leadership is nonetheless essential for organisational development in response to demands (Cook 1998). So much so that Dubois et al. (2006) affirmed that “the context in which a health care organization achieves its aims and objectives (reforming or otherwise) is so complex that without firm, clear leadership and strong, effective management practices it is almost inevitable that it will lose direction” (p.130).

Therefore, as healthcare organisations tackle new challenges, managers need to be more creative and innovative, and maintain stability within a context characterised by rapid change and by increasing complexity in healthcare provision (Mickan and Boyce 2007; Oliver 2006). Consequently, more prominence is being placed on healthcare leadership. Hartley et al. (2008) reviewed the literature on leadership and leadership development in the previous 10 years, mainly but not exclusively in healthcare, and argued how the National Health Service (NHS) plan in the United Kingdom (UK) needed to pay more attention to leadership and the development of leaders. More recently, Robert Francis highlighted the failings at the Mid Staffordshire Foundation Trust. He specifically identified “poor leadership” as one of the significant factors culminating to the effects described in the report (Francis 2013, p.25). Since then, healthcare leadership in the UK has been in the public eye more than ever. Certainly,

managers have a contribution to make, and may influence performance, individual wellbeing, issues of patient safety, quality of care and clinical outcomes towards the delivery of high-quality care (Francis 2013; Nielson and Munir 2009).

2.5.1 The local context

Healthcare in Malta is likewise undergoing changes and extensive health reforms are being implemented (Azzopardi Muscat et al. 2014; Micheli et al. 2003). In the past decade, health reform in Malta has been characterised and shaped by Malta's accession to the EU in 2004, and the construction of the new acute hospital, MDH, in 2007. This has introduced medical, pharmaceutical and technological advances. Recruitment, training and retention of highly skilled competent healthcare professionals have been another major challenge (Azzopardi Muscat et al. 2014).

Coupled with these demands are demographic realities, comprising a continuously ageing population, increased longevity, health inequalities, projected rise in people with chronic and long-term conditions; lifestyle and activity demands; and education and greater societal expectations (Azzopardi Muscat et al. 2014). The ageing population is the leading cause of health service demands on acute services (Ministry for Finance 2013). Based on projections compiled by the National Statistics Office (2015), by 2080, expectation of life at birth will see a linear increase to 87.2 and 91.1 years respectively for males and females. In fact, the cost of treating an ageing population was identified as the most difficult challenge facing health systems. As age increases, the percentage of hospital admissions also increases. According to national data, 22% of those aged between 60 and 74, and 53% of those aged 85 and over were admitted to hospital in 2008 (Department of Health Information and Research 2008). Besides the increasing health needs of an ageing population, chronic diseases and disabilities also pose increased demands on acute healthcare, impacting the sustainability of public finances (Azzopardi Muscat et al. 2014).

Similar to healthcare organisations worldwide, the emerging demands of a dynamic healthcare system have resulted in local healthcare managers needing to respond to a wide range of complexities and challenges. In recognition of these factors, the local healthcare organisation has increasingly acknowledged the need to enhance efficiency and effectiveness through improved hospital management and quality assurance procedures, amongst other measures (Azzopardi et al. 2014). This posed further significant pressures on healthcare managers and led to demotivation and cynicism amongst health professionals. This situation seriously concerned MFH (Micallef 2011), re-enforcing Hannah et al.'s (2009) assertion that complexity may generate unpredictable outcomes. Consequently, in 2006, an intervention plan was initiated by MFH to integrate the well-being of healthcare professionals and organisational development.

The aim of the plan was to nurture a foundation for internal improvement, competence and sustainability of healthcare managers within the health organisation, together with a simultaneous obligation of competent leadership and management, and quality service provision, safety and sustainability (Micallef 2011).

2.5.2 Effect of leadership on the organisation

Middle managers have a significant leadership impact on organisational innovation, effectiveness and efficiency. This was contended by Birken et al. (2012) as they discussed how middle managers may influence the effectiveness of healthcare innovation implementation. Furthermore, Spinks and Wells (1995) asserted that effective leadership motivated employees and this in turn was beneficial to the organisation. Similarly, when reviewing the “romanticized conception of leadership” using a number of experimental studies, Meindl et al. (1985, p.96) reflected on how leadership may have the ability to control and influence organisations, being given credit for both positive and negative outcomes. These researchers challenged the earlier arguments by Pfeffer (1977) who by way of contrast contradicted the “romanticized conception of leadership”, and argued that leadership in organisations is not as significant to organisational effectiveness as researchers believe it is. Pfeffer (1977) proposed that organisational functioning may depend on other factors beyond the leadership control of the manager. From the literature, it appeared that researchers may not always take into account the important fact that leaders and leadership are only two variables that account for organisational outcomes. In essence, leadership may not have the impact on organisations that researchers claim it has, particularly in complex settings. This was revealed in a study with 40 senior managers at middle levels. Alvesson and Sveningsson (2003a) were investigating leadership and managerial work in a knowledge-intensive industrial setting. Study results emphasised the importance of understanding specific settings, and not draw conclusions about leadership on a general level.

Leadership in a healthcare context is a “way of thinking and a way of behaving...about effecting change and enabling others to think and behave differently in order to bring about positive improvements in the experience of patients and service users, through redesigning the current systems of care that are offered” (Pond 2006, p.100). It has also been argued that leadership is associated with “the effective and efficient resolution of problems” (Grint 2005, p.1478). It follows that leadership is a complex process (Lavine 2014; Nicolson et al. 2010) and presents a major challenge, especially in complex organisations such as healthcare (Denis et al. 2000). When interviewing 16 nurse leaders from 4 acute care hospitals for their perception of leadership traits effective in the inpatient hospital setting, Upenieks (2002) added that “[t]he distinctive attributes of the healthcare environment, especially in the acute inpatient setting” make healthcare leadership particularly demanding and complex (p.622). Pond (2006) further reported that the more effective healthcare leaders are able to tolerate complexity and

ambiguity, whilst Wong and Cummings (2007), in their systematic review of relationships between nursing leadership and patient outcomes, suggested that effective leadership and management practices may influence organisational outcomes through adaptability of behaviour based on changing demands.

Meanwhile, Nicolson et al. (2010) posited that leadership and patient care are intrinsically linked. These researchers highlighted that effective leadership and management in healthcare organisations are key for staff members, patients and carers. This was evidenced in a study focusing on 3 NHS trusts in the UK. The researchers' aim was to explore the meanings and perceptions of relationships between leadership and patient care, and how leadership is transmitted across organisational contexts to impact upon quality of service delivery. As part of the study, clinicians, managerial staff, as well as patients were interviewed. Meanwhile, Harteloh (2003) cautioned that healthcare quality is an abstract term. In his paper review, this scholar postulated that healthcare quality does not exist but it is "constructed in an interaction between people" (p.259) and is context dependent.

This first concept of the healthcare context contextualised the research study being presented in this thesis, and has provided an understanding of the working environment of nurse and allied health middle managers participating in this study. The literature highlighted the difficulties, complexities, and the effect of leadership within the healthcare environment. This study will seek to explore whether or not similar challenges impact healthcare middle managers in their leadership experience in the context of Malta, precisely middle managers at MDH. The leadership experience of middle managers will now be reviewed against the background of middle managers working in a healthcare organisation. This is the focus of the second concept of literature.

2.6 Concept two: middle managers' leadership perceptions

The healthcare literature describes a number of characteristics of the leadership perceptions of middle managers. For the purpose of this study, this second concept addressed 3 identified aspects of leadership perceptions: middle managers' role, emotions and interpersonal relationships. These aspects were selected because they were thought to explain the complexity, contradictions and paradox inherent in middle management leadership. They are also directly linked to the interview questions regarding middle managers' leadership experience. The expectation was that an understanding of the impact of these aspects would provide an understanding of the leadership perceptions of healthcare middle managers working in an acute healthcare setting.

2.6.1 Middle managers' role

In healthcare and in other sectors, middle management is difficult to define. There are ambiguities regarding middle managers' responsibilities, and the nature of their work is complex and contradictory giving rise to role conflict (Buchanan et al. 2013; McConville and Holden 1999). Meanwhile, research evidence on the contribution of middle managers regardless of sector, presumes that middle managers either have little to contribute (Buchanan et al. 2013; Currie 2000; Dopson et al. 1992) or else are a major source of resistance within their organisation (Embertson 2006; Dopson and Neumann 1988). Healthcare middle managers with a clinical background have even been described as the "neglected thick waist" (Czarniawska-Joerges 1988, cited by Currie 1999, p.45). Currie (2006), Balogun (2003) and Huy (2002) challenged this pessimistic and gloomy assumption. They argued that researchers often place an emphasis on middle managers' negativity and very often, this distorts their proactive contribution, albeit their unique challenges and responsibilities. In considering this debate, Currie (2006) suggested that this negative view of healthcare middle managers may have come about because middle managers "do not form a well-defined homogenous group that can be differentiated easily from executive managers and from first-line managers" (p.6). It follows that researchers may have included a broad spectrum of managers in their scholarly work, resulting in inadequate results.

Scholars have suggested that middle managers provide strategic and implementation influence related to improved organisational performance (Buchanan et al. 2013; Currie 2006; Currie and Procter 2005; Currie 1999; Floyd 1997). Floyd and Wooldridge (1994) conducted research focusing on 259 middle managers from 25 organisations representing various industries. They also uncovered a strong relationship between middle management roles and positive organisational performance. These authors concluded that "middle managers are likely to become more, rather than less, important in the organizations of tomorrow" (p.56), mainly in translating strategies defined at higher levels into actions at clinical level. Similarly, Inamdar et al. (2010) stated that middle managers are known to be responsible and to contribute to clinical and organisational outcomes, providing consistency and control especially during periods of organisational restructuring. This requires them to interpret and shape strategy through the way they connect the operational core with senior management. In fact, middle managers are considered to be the "linking pins" (Likert 1961, cited by Floyd and Woodridge 1992, p.154), linking vertically related groups (Currie 2006), and having an intermediating role in both upward and downward influences on strategy formation (Buchanan et al. 2013; Currie and Procter 2005). Middle managers also influence laterally (Rouleau and Balogun 2011). Furthermore, Dutton et al. (1997) suggested that since middle managers are renowned for being generally close to stakeholders within organisations, they establish pivotal links in influencing issues, communicating information, ideas and resources to senior management. These scholars

contended that middle managers' important and critical contribution influences organisational effectiveness. Therefore, middle managers, rather than the more senior managers are closer to front-line professional staff and so more attuned to their needs (Huy 2002), putting them in a position where they are able to help senior managers expand their influence over front-line staff (Caughron and Mumford 2012). These arguments suggest that middle managers achieve a sense of involvement and inclusion within their organisation setting. This enhances their self-development and certainly gives them a more active role (Balogun 2003), as opposed to exclusion which results in demotivation and inefficiency (Westely 1990).

Due to their position within the hierarchy, healthcare managers are often caught in conflict situations in a constantly changing healthcare environment (McPhail 1997). Using David Sims's (2003) provocative wording, middle managers very often find themselves caught "between the millstones" (p.1195) in uniquely vulnerable positions. Sims (2003) considered the pressure and expectations middle managers experience from both their superiors and subordinates. "The plot is no longer their own" as they have to face "a number of confusing and conflicting audiences" (p.1208). Carlström (2012) was interested in examining how the role of middle managers in Swedish healthcare changed in times of pressure and constraints. He speculated how healthcare middle managers may be tested in their loyalty as they become thorn in between their employees and senior management, thus highlighting once again middle managers' paradoxical position. Moreover, exercising leadership in healthcare means "being faced with daunting challenges, including complex organizational structures, unfamiliar operational and strategic issues, and rapid change" (Downey-Ennis and Harrington 2002, pp.68-69). Therefore, leadership competencies are required helping leaders to deal with stress and to focus on leadership values within the demands of an ever changing complex healthcare system (Dye 2000).

Through a case study focusing on middle managers in 2 UK hospitals offering acute medical and surgical services, McConville and Holden (1999) demonstrated that healthcare middle managers experience tensions and role conflicts inherent in their position. These tensions are enhanced due to increasing demands and expectations of their roles and also, because they bear many of the consequences of the change process. Buchanan et al. (2013) added to this discussion. A project was conducted with 1200 managers in 6 acute trusts in the UK through interviews, focus groups, management briefings, a survey with 600 responses, and serious incident case studies. The project researchers identified the pressures and demands experienced by middle managers in their continuously changing roles. Some of these pressures and demands included financial challenges, workload, regulation, poor information systems, relations with external agencies, implementing change and staffing difficulties. Middle managers' contribution to clinical and organisational outcomes was also explored. Dimensions of management

contribution included day-to-day performance, facilitating change, troubleshooting, fire fighting, developing others and focusing on patient experience.

Dopson and Stewart (1990) studied 8 public and private sector organisations in 6 western European countries. They found that notwithstanding the complexity of changes affecting middle managers' jobs, and despite the complexity of individual reactions to the changes, middle managers were able to respond to complex and changing pressures, and were pivotal to implementing change. Mickan and Boyce (2007) echoed this view, affirming that healthcare middle managers have a crucial role in change situations, and though there may be a number of managers who are resistant to change, many have a positive attitude towards change, especially when they are engaged and have some influence in the change process. It is not surprising that Wong and Cummings (2007) revealed that positive leadership practices in healthcare are associated with better outcomes. These nurse researchers were interested in examining the relationship between nursing leadership and organisational outcomes.

The literature on middle managers lends support to the notion indicated by the CVF because it clearly recognises the wide range of paradoxical situations, competing demands and role conflicts that healthcare middle managers are believed to experience in an acute healthcare setting. Furthermore, the literature illustrates that healthcare leadership changes regularly and often unpredictably. Hence, the specific link of the CVF to middle managers' leadership perceptions in this study as defined by their role, emotions and interpersonal relationships. When faced with complexity of choices, middle managers are able to face adaptation and change (Melo et al. 2014), and therefore, are said to possess leadership competencies and able to exercise effective leadership (Lawrence et al. 2009; Belasen and Frank 2008; Quinn 1988). Consequently, middle managers who can balance various competing demands and expectations can better meet the organisational demands of an acute healthcare setting. This is underscored by the CVF through the leadership dimensions highlighted in Figure 2.2.

In summary, middle managers occupy crucial strategic roles, even though their contributions are very often unrecognised (Caughron and Mumford 2012; Floyd and Wooldridge 1994). Middle managers within healthcare are very resourceful and key facilitators of change and innovation in raising levels of performance and quality of patient care in an increasingly complex, exciting and dynamic healthcare system (Embertson 2006). The middle management level appears to possess strategic roles crucial to developing organisational capability. However, despite this acknowledgement of their central role, in a study exploring the realities of middle and front line management work in 6 acute trusts and 1 primary care trust in the UK, Parry and Buchanan (2011) concluded that healthcare middle managers are still "undervalued, overstretched and often underutilised" (p.13).

2.6.2 Emotions

Organisations have been depicted as “emotional arenas” (Fineman 1993, p.9) giving rise to strong emotions (Gabriel and Griffiths 2002; Frost and Robinson 1999). McColl-Kennedy and Anderson (2002) argued that employees in organisations are exposed to multiple interactions with colleagues and their leaders. Such interactions produce emotions. Hence, due to its inherent complexities, the experience of work has been aptly described to be “saturated with emotion”, with emotions being “an integral and inseparable part of organizational life” (Ashforth and Humphrey 1995, p.97). Fotaki (2006) supported this view, adding that emotional affective relations are particularly strong in healthcare, possibly shaping encounters in healthcare settings. Using a different but complementary rationale, Holland (2007) suggested that emotions may be important in the production of knowledge and called for in qualitative research. This indicates that emotions are important in research as these can shape middle managers’ perceptions and understanding of their leadership, and their capacity to perform in healthcare contexts.

Equally, Gabriel (2010) proposed that emotions are capable of supporting organisational activities and demands, helping employees to cope with contradiction, conflict and confusion, and give a more holistic perception of the experience of work and hence, of leadership. Yet, it is surprising how until recently, the “role of everyday emotion in mundane organizational life” has been neglected (Ashforth and Humphrey 1995, p.98). McConville and Holden (1999, p.406) echoed this view when researching middle managers in 2 acute hospitals in the UK. They revealed that the emotional needs of middle managers who must “act as a buffer” between the decision-makers and their staff, are largely neglected. This may be because emotions in organisations are largely devalued with respect to rationality (Tomagalski 1999). However, in a longitudinal study, van Dierendonck et al. (2004) acknowledged that the relationship between seniors and subordinate staff may be one of the most common sources of stress within an organisation. van Dierendonck et al. (2004) were investigating the relationship between leadership behaviour and the well-being of 262 staff members in 2 community trusts. In his interview with Harris (1993), Peter F. Drucker likewise explained the complexity of organisations and jobs, and stressed that leaders in management positions “have to learn to manage situations where [they] don’t have command authority, where [they] are neither controlled nor controlling” (p.115). These arguments further underline the value of emotions emanating from organisations.

Hochschild (1979) theorised that all relationships involve emotion management rendering them appropriate to situations. In an attempt to develop Hochschild’s (2003; 1979) notion of emotion and emotion management, Theodosius (2006) carried out 14 months of participant observation of nurses on an acute surgical ward, used audio diaries and carried out interviews with 15 nurses

who worked there. She demonstrated that hidden emotion amongst nurses may be recovered through identification of hidden unconscious emotion processes. In fact, a range of emotional aspects of leading by middle managers has been identified in the literature, as middle managers and their subordinates feel and display emotion. Emotions expressed by leaders in the workplace range from optimism, joy, enthusiasm and satisfaction, to frustration, anxiety, fear, uncertainty, sadness and anger (McColl-Kennedy and Anderson 2002; Lewis 2000). Similarly, drawing from interviews with middle managers working in various organisations, Thomas and Linstead (2002) revealed the emotional responses of employees and how organisations are imbued with emotion. These scholars reported that the existing pressures, dynamism, as well as “the blurred boundaries around the ‘middle’” (p.88) trigger feelings of uncertainties, anger, ambiguity, distress and frustrations within middle managers. Healthcare middle managers also experience stress and fatigue associated with the complexity of their role and with their attempts to drive change and innovation (Buchanan et al. 2013). It is not surprising that in her pioneering study of nursing staff, Menzies (1960) raised concerns that unresolved emotions such as anxieties in relation to hospital staff, will adversely affect staff welfare and eventually patient care.

Indeed, leadership itself may evoke complex emotions (Gabriel 2010; Ciulla 2009). Emotions may potentially influence feelings, attitudes and behaviours, and therefore, one’s inspirational motivation and performance, raising levels of optimism and enthusiasm (McColl-Kennedy and Anderson 2002; Lewis 2000). It follows that optimistic middle managers tend to have positive feelings about their leadership realities and engage in positive thinking to achieve goals. In contrast, middle managers having a negative viewpoint will not put the same level of effort, and this impacts on their leadership and performance. Positive and negative emotions expressed by leaders are also thought to influence the perception of followers on the leader’s effectiveness, suggesting that middle managers’ leadership influences employees through expression of emotion (Lewis 2000).

Buchanan et al. (2013) reported that there are upbeat accounts of emotions, suggesting that the leadership realities of middle managers may also be exciting, optimistic and fulfilling for some. Making a difference, feeling valued, recognition, overcoming challenges, personal accomplishment, developing others, and improving patient care and safety were some of the positive emotions identified in middle and front-line managers across 6 hospitals (Buchanan et al. 2013). Moreover, organisational effectiveness may be improved through the celebration of emotion, rather than inhibiting the expression of emotion in the workplace (Ashforth and Humphrey 1995). Therefore, it appears that organisations need to recognise the importance of workplace emotions and “the functional complementarity of emotionality and rationality” (p.120) as certainly emotions are not opposed to rationality (Gabriel 2010).

Scholars contended that caring for subordinates is an emotion, which may be experienced in organisations, and which is essential for leadership (Gabriel 2010; Ciulla 2009). Ciulla (2009, p.3) defined care as “attention to what is going on in the world and emotional concern about the well-being of others.” Caring is being “increasingly recognised as a vital dimension of most human interactions” (Gabriel 2010, p.48), and is also a predominant feature of service work and caring professions, such as nursing and allied health professions (Gabriel 2010). Managers who care have been described as those “who are willing to give generously their time, advice, recognition and support; who are genuinely concerned for the realisation of a mission or a project and who are prepared to treat others with consideration and respect, rather than pawns on a chessboard” (Gabriel 2010, p.51). Cartor (1993, cited by McPhail 1997, p.203) posited that caring in a healthcare organisation is “vital to establishing trust, credibility and support,” whilst Pond (2006) maintained that caring is “the ‘bedrock’ of effective leadership” (p.108). Moreover, in his paper examining the moral standing of leaders from followers’ point of view, and using illustrations from hospital leadership, Gabriel (2015b) argued that leaders are very often expected by their employees to demonstrate that they care for the organisation and its staff members through recognition and support. Notwithstanding, care and other emotions have not been adequately addressed in healthcare and in organisational life (Lökman et al. 2011), even though emotions have been an “implicit feature of research since the dawn of human relations perspective” (Ashforth and Humphrey 1995, p.98).

2.6.3 Interpersonal relationships

“Effective leadership does not exist in a vacuum, but as a function of the relationship between people working together in a system” (Pond 2006, p.104). Such a statement is reminiscent of the finding in Mintzberg’s study (1973, p.17). Mintzberg (1973) emphasised the relational and interpersonal concepts of leadership. He described the manager’s job using findings of empirical studies conducted internationally throughout many levels of management. Day (2000) shared this leadership perspective. Drawing on leadership research on leader and leadership development, he summarised that leadership is “a complex interaction between individuals and their social and organizational environments” (p.605).

Along similar lines, Yukl (2010) argued that leaders function within a complex network within and outside their organisation. This requires extensive interaction, both hierarchically and laterally. As managers advance in their careers, the behavioural demands of this complex network appear to increase. Other researchers suggested that in addition to leading downwards, leaders also lead upward and laterally (Hooijberg et al. 1997). Furthermore, Osborn et al. (2002) considered that leadership is not simply an interaction between a leader and subordinates. As well as subordinates, leaders are also involved with superiors and peers “in a collective influence to both cope with a crisis and change the context” (p.809). This suggests that such

interactions in critical situations may play a part in sustaining effective performance within the organisational context. Hannah et al. (2009) supported this assertion and posited that these situations allow “different leaders to emerge while others recover” (p.903). Hence, the dimensions of leadership emerge from actions and interactions, and are embedded in time, place and the person experiencing it.

Gabriel (1997) introduced a different but complementary rationale to the relation dynamics between the leader and the employee, and to the emotional needs of employees. He used narratives supplied by students on industrial placements to focus on the relationship between the leader and the follower. Gabriel (1997) advocated that employees fantasise about their managers and “often make superhuman demands on their leaders, elevating them to heights from which they can rarely fail but disappoint” (p.317), without realising that those exercising leadership “are only human and fallible, that they too are afraid and that they too may be driven by someone standing above them” (p.331). In her seminal contribution exploring the nursing system of a hospital, Menzies (1960) shared a similar perspective. She contended that nurses depend on their superiors and make demands on them, therefore projecting their dependency on them. It has also been suggested that middle managers in particular, play the role of “toxic handlers” for employees who “voluntarily shoulder the sadness and the anger that are endemic to organizational life” at a cost to the health of the middle managers themselves (Frost and Robinson 1999, p.98).

Meanwhile, van der Kam et al. (2014) conducted a study in an educational institution and a mental institution in the Netherlands. They used a sample of 52 leaders working with 259 subordinates to investigate the role of vertical conflict in the relationship between leader self-enhancement and leader performance. These scholars revealed the high expectations required of leaders, putting pressure on them to be more considerate, supportive and sensitive toward their subordinates’ needs and feelings. So much so that low leader performance may be a potential outcome of vertical relationship, and vertical task and emotional conflicts between leaders and subordinates. Vertical task conflict is the inability of the leader to align the goals of subordinates to the organisation’s goals (van der Kam et al. 2014), whilst emotional conflict results from the interpersonal compatibilities amongst employees (Xin and Pelled 2003). In their study of 72 superior-subordinate pairs at the upper management levels of high-technology organisations, Xin and Pelled (2003) revealed that employees experiencing emotional conflict with their superiors, perceived their leaders to be unable to offer emotional support and promote encouragement through innovative thought processes.

These interpersonal relationship experiences between leaders and employees have raised awareness on the influence of the support received by leaders from their own superiors,

simultaneously increasing recognition that workplace situations and leadership are main causes of stress for the workforce (van Dierendonck et al. 2004). In their study investigating the relationship between leadership behaviour and the well-being of employees in the British NHS, these scholars reported that employees are influenced by the support received by their superiors, with this reflecting positively on the employees' positive emotions about themselves, the settings in which they work and stress levels. Likewise, employees who feel confident due to the support given by their superiors will be able to enjoy greater influence over their own subordinates. This was also reported by Caughron and Mumford (2012) in their research with 224 college students in an American university, where they investigated the effect superiors have on the leadership and cognition of middle managers. The study procedure consisted of a scenario in which participants assumed the role of middle managers of a manufacturing organisation. Moreover, leaders' morale improved and feelings of optimism were elicited when their individual contributions and efforts were identified by their superiors, and they realised that they were not only working for their own personal benefit. It follows that middle managers who feel good about themselves may in turn stimulate and reinforce positive leadership with their own subordinates, supporting the "proposition that the relationship between leader and subordinate is a two-way reciprocal process" (van Dierendonck et al. 2004, p.173). This also impacts on performance (McColl-Kennedy and Anderson 2002).

The varied nature of healthcare middle managers' leadership roles, including their interpersonal relations, calls for the provision of better forms of support. Mickan and Boyce (2007) raised awareness that management support is required for motivating middle managers to undertake their roles, as support influences how employees experience leadership. In fact, in a study done in a Los Angeles County hospital with over 500 inpatient beds and extensive outpatient services, McNeese-Smith (1999) proposed that positive nursing leadership experiences were correlated with improved job satisfaction, motivation and patient outcomes. In contrast, Kokkinen et al. (2007) reported how healthcare middle managers in a Finnish hospital felt unappreciated when they received lack of feedback and the support they needed from their superiors. The researchers concluded that the realities of healthcare middle managers are not well understood in the social and healthcare sectors.

Moreover, Scott (2002) conducted a research study carried out over a 2-year period in an NHS region in 4 acute and 3 community trusts in the UK. She was interested in examining the role of middle managers and the relationship between the length of time they wished to stay within their organisation and their perceptions of being valued. She reported that when middle managers felt valued and involved in decision-making, there was better retention of middle managers and organisational effectiveness. This explains why consistent support from seniors eases the demands on healthcare middle managers and enhances their sense of self-worth

towards higher levels of performance. However, support for hospital staff against the anxieties experienced appears to be lacking (Theodosius 2006). For example, Carlström (2012) studied 25 Swedish middle managers working in hospitals and primary care to examine their role in healthcare during downsizing in times of cost savings. He concluded that healthcare middle managers “need support to keep up the important work in the middle” (p.101) and to affect better interpersonal relations.

In a dissenting voice, Caughron and Mumford (2012) disputed that it was not entirely clear whether support actually resulted in better middle management performance and better interactions within the organisation. Similarly, when reviewing a number of studies, van Dierendonck et al. (2004) summarised that evidence on the positive relationship between support from seniors and employee well-being is lacking, and more research is warranted.

The background to this second concept of literature has underlined the complexities of role, emotions and interpersonal relationships inherent in the leadership perceptions of middle managers, and how these influence the workplace realities of middle managers. In this study, I sought to understand the meaning of middle managers’ role, emotions and interpersonal relationships for middle managers working within the acute healthcare setting of MDH. To further understand the everyday realities of middle managers exercising leadership within an acute healthcare setting, middle managers’ training and leadership development needs will now be discussed.

2.7 Concept three: middle managers’ training and leadership development needs

The third concept of literature focuses on middle managers’ training and leadership development needs, characterised by middle managers’ preparation for their role, effectiveness of training and improving professional development practices. The realities of exercising leadership in a complex organisation may pose a major challenge for healthcare middle managers. Day (2000) aptly described leadership development as being “oriented to building capacity in anticipation of unforeseen challenges” (p.582).

2.7.1 Middle managers’ preparation for their role

Hooijberg (1996, p.919) described behavioural complexity as a concept that acknowledges that managers have to “manage a network of relationships that includes superiors and peers as well as subordinates.” He was exploring the behavioural repertoire of 282 middle managers of a large manufacturing company and 252 managers from a public utility industry. Consequently, as this network of relationships grows, so does the “potential for paradox and contradiction,” especially if managers have to perform across a variety of situations within an organisational context. Within an organisation, a behaviourally complex leader is one who has the ability to

“perform the multiple roles and behaviors that circumscribe the requisite variety implied by an organizational or environmental context” (Denison et al. 1995, p.526). The concept of behavioural complexity for effective leadership has been given attention within the organisational literature, particularly for addressing the competing demands and roles expected of managerial leaders. Higher behavioural complexity is in fact related to higher managerial and leadership effectiveness (Lawrence et al. 2009; Hooijberg 1996; Denison et al. 1995; Hart and Quinn 1993). Leader expectations from subordinates, as well as peers and superiors are considered as key factors influencing the behaviour of leaders (Hooijberg et al. 1997). In a study testing the relationship between leadership roles and organisational performance with 916 top managers from American organisations of all types and sizes, Hart and Quinn (1993) found that the highest levels of performance were achieved by top managers with high levels of behavioural complexity, that is those who were able to play multiple, competing roles.

Meanwhile, Denison et al. (1995) maintained that traditional leadership and management theories have often divided the leadership phenomenon into contrasting categories, with leaders being matched and grouped to various behaviours and situations in order to produce effective leadership. However, more recent theory has emphasised a more complex paradoxical perspective of effective leadership, with both cognitive and behavioural complexity being necessary ingredients for the effective practice of leadership at individual and organisational levels. For instance, Denison et al. (1995) studied 176 mid-level executives drawn from different companies in public utilities. Each participant selected 3-7 direct subordinates who knew them well and they were asked to respond to a questionnaire, which included a set of items measuring the 8 roles specified by the CVF. In support of earlier views by Hart and Quinn (1993), Denison et al. (1995) found that effective managers demonstrated higher degree of leadership complexity and a greater variety of leadership roles than less effective leaders. They argued that “effective leaders are those who have the cognitive and behavioral complexity to respond appropriately to a wide range of situations that may in fact require contrary or opposing behaviors” (p.526). Furthermore, Hooijberg et al. (1997) raised awareness that although researchers had previously considered the social, cognitive and behavioural aspects of leadership separately in order to understand leadership, a more integrative framework of all 3 aspects was required. This underscored the understanding that leaders are more likely to function effectively and perform more varied leadership roles if they are prepared and taught to develop their leadership.

Drawing on 3 empirical case studies researching organisational change in healthcare organisations, Denis et al. (2010) further described the practice of leadership in healthcare organisations as a dynamic “process that evolves over time in context” (p.72). Tensions, contradictions, a degree of uncertainty and ambiguities typically characterise such leadership

dynamics (Collinson 2005; Grint 2005; Alvesson and Sveningsson 2003b). This statement reflected what Hart and Quinn (1993) had highlighted 10 years earlier, namely that “effective leadership requires a balancing and simultaneous mastery of seemingly contradictory or “paradoxical” capabilities” (p.544), suggesting that managers exercising effective leadership must be prepared to be able to play multiple and competing roles within an organisation. These research findings showed a remarkable degree of correlation to the varied roles describing middle management in healthcare as illustrated by the CVF. Therefore, overcoming the obstacles of complex healthcare systems and managing the behavioural complexities inherent in middle managers’ leadership roles requires preparation, leadership development, and knowledge and skills training that maximise the likelihood of healthcare managers to function more effectively as leaders (Snell and Dickson 2011; Downey-Ennis and Harrington 2002; McConville and Holden 1999).

In addition, in her phenomenological study exploring the experiences of first-time healthcare leaders working in organisations throughout California, Stringer (2014) suggested that preparation was essential to leadership development and success of healthcare organisations. She added that since leadership was key for one’s success or failure, organisations had to have programmes in place to prepare future leaders. Besides, in healthcare organisations in general, it has been reported that there is limited leadership education and training preparation for employees in management positions (Mickan and Boyce 2007). Consequently, in view of the complex realities of middle managers in exercising leadership, preparation for their role is a stated expectation, crucial to their performance, as well as the organisation’s performance.

2.7.2 Effectiveness of training

In a study with 114 graduating public health leadership scholars in the US, Saleh et al. (2004) acknowledged that leadership development through training is necessary to address leadership competencies. The leadership training programme that the scholars participated in was found to be effective in improving the skills and knowledge of participants in responding to the ever-changing healthcare challenges. In their online survey with 210 participants from the National Public Health Leadership Institute evaluating the effects of participation in leadership programmes, Miller et al. (2007) likewise reported that organisations benefited from employees who participated in these programmes. Some of the benefits mentioned were changed leadership understanding, knowledge and skill development, increased confidence, increased self-awareness, leadership practice changes and organisational results.

Similarly, Woltring et al. (2003) presented results of an 8 year retrospective evaluation at the University of California Public Health Leadership Institute. They evaluated the leadership development programme for 456 senior public health leaders using a mixed method approach to

obtain a variety of perspectives on the impact of training on the participants themselves and on the field of public health. Skills training areas included personal growth, leading organisational change, community building and collaborative leadership, leadership in training others and communications. The study demonstrated that leadership training had a “measurable impact on scholars’ leadership effectiveness at the personal, organisational, and community levels as well as on the field of public health” (p.125). Likewise, in a systematic review of the relationship between nursing leadership and patient outcomes, Wong and Cummings (2007) suggested that developing leadership was an important organisational strategy to improve patient outcomes. Besides, in a longitudinal survey study with 447 healthcare staff in a Danish elderly care department, it was revealed that training managers in leadership is likely to promote subordinates’ well-being and achieve positive effects in employees (Nielson and Munir 2009).

Other researchers had additional perspectives on training. Reviewing earlier reports, Fiedler (1996) argued that “while the number of available training programmes in leadership and management development was considerable and continued to grow at an increasing pace, the scarcity of sound research on training had been among the most glaring shortcomings in the leadership area” (p.243). These scholars affirmed that the leadership and management training field was “characterised by continual discussion but very little research.” Saari et al. (1988) took a similar position. They stated that little research on evaluations of leadership and management training courses for professionals had been carried out in the States, and when they were tested, they were of uncertain value. For instance, Woltring et al. (2003) pointed out that little was documented on the effects of leadership training because these training programmes are challenging to evaluate due to the difficulty of attributing organisational changes to the impact of leadership training on managers. Parry and Sinha (2005) and Day (2000) added that though a number of leadership development initiatives existed, organisations were not adequately evaluating the effectiveness of these training initiatives. Snell and Dickson (2011) shared this perspective, arguing that little research existed that explored the leadership experience of health workers after participating in leadership development programmes. Therefore, they conducted a qualitative study with 54 health professionals of all types after taking leadership development programmes varying from 2 days to 2 years. The study findings showed that participants gained knowledge from the programmes, and they were able to implement their skills in the workplace, especially in supportive workplaces.

Nevertheless, dissenting voices amongst researchers with regards to effectiveness of leadership training and development for managers exist. After a review of the literature on leadership development, Day (2000) explained that findings about the impact of leadership training and development are unclear and vary. House and Aditya (1997) insisted that despite the investment in training, there is little evidence that training results in increased knowledge and more

effective management and leadership. Moreover, in a meta-analysis applied to the results of 70 different management training studies, Burke and Day (1986) noted that only a moderate improvement in leadership practices was found, partly because of the different training methods used across various settings, as well as training content and trainer experience. Equally, in their literature review on leadership training and development, Parry and Sinha (2005) asserted that it is unclear how managerial leadership development contributes to individual knowledge, expertise and organisational development. Hence, more research is required before conclusions may be drawn.

2.7.3 Improving professional development practices

An important component in healthcare leadership development is the difference between leader development and leadership development. Edmonstone (2011) emphasised an important distinction in the development of leaders and leadership in healthcare. He underlined that leader development focuses on the enhancement of the individual leader, whilst leadership development “focuses on the development of leadership as a process, which includes interpersonal relationships (between “leader”, “followers” and colleagues), the social influence process, team dynamics all situated within the all-important context” (p.11). The challenges that leaders face provide a foundation for leadership development. Consequently, by developing leadership, individual leaders will also develop.

Bergman et al. (2009) conducted a study with 53 healthcare managers in a major hospital in Sweden to study the impact of two leadership programmes on managers’ attitudes to leadership, and their views on their leadership. The programmes consisted of a 1-week intensive leadership course and long-term support groups. The researchers found that healthcare managers benefited from a combination of the 2 complimentary training programmes. They added that the 1-week leadership course supported the managers in group dynamics and relationship-oriented leadership, and was good for the inexperienced managers, whilst the long-term support groups helped managers to manage their daily leadership situations, and was of more benefit to the experienced managers.

Alternatively, Yukl (2010, p.432), when reviewing the work of a number of researchers affirmed that effective leadership is largely learnt through experience, rather than from formal training programmes. Similarly, in a qualitative study with 22 hospital healthcare managers working in Swedish hospitals, Nilsson and Furåker (2012) found that head nurses and physicians from different Swedish departments and hospitals, emphasised the importance of experience and interpersonal relations when they were asked about leadership development and learning. Moreover, Pond (2006) and Baker (2001) argued that leadership develops through a combination of knowledge, experience and reflection. Furthermore, Crethar et al. (2011)

reported that leadership development programmes for clinical and non-clinical staff organised by Queensland Department of Health, Australia were based on experiential learning. These programmes engaged participants in “critical thinking and self-reflection based upon in-context experiences relevant to themselves” (p.308).

Redman (2006) raised awareness that leadership learning opportunities, mentoring and coaching are essential for leadership development even in the absence of formal training programmes. Additionally, Groves (2007) studied 30 senior executives across 15 healthcare organisations in the States. Seeking practical recommendations for optimal leadership development, he asked participants to describe the leadership development practices within their organisations. Findings included developing mentoring, using learning experiences, action learning and establishing a supportive culture within the workplace.

Hewison and Griffiths (2004) remarked that it is vital that participants on leadership development training initiatives are supported once the programme is completed. These researchers reviewed the evidence concerning leadership development in nursing in the UK. They suggested that “leadership development for individuals will only bring about the anticipated changes if the organisations within the NHS allow and indeed, enable leaders to lead” (p.467). Snell and Dickson (2011) corroborated this view when they explored the workplace leadership experiences of individuals working across a number of Canadian healthcare organisations, who had participated in leadership development programmes. From their research it emerged that participants were able to implement the skills and knowledge learnt in those healthcare organisations that were receptive to their leadership efforts. Certainly, organisational support for leadership development training is key for a positive impact on leadership and management practices in the workplace.

Indeed, there are limits to what can be gained from managers’ leadership training and development, and more research evidence is warranted to examine professional development practices (Parry and Sinha 2005). For instance, House and Aditja (1997) hypothesised that only those individuals who are disposed towards exercising effective leadership and management practices will benefit from training. This underlines the need for effective leadership development practices that are critical in changing healthcare environments.

Clearly, the literature in relation to leadership needs and training development shows that one size does not fit all. Middle managers’ complex and contradictory roles require them to be adequately trained so as to be able to provide effective leadership. This is critical for the well-being of an acute healthcare context. Indeed, the CVF may be directly applied to training and leadership development needs (Giek and Lees 1993) because it helps healthcare middle

managers understand better the leadership competencies required for various situations, and at various levels of the hierarchy (DiPadova and Faerman 1993). The CVF may also be used as a means to develop and support leadership competencies from a paradox perspective. In fact, the CVF may be utilised to “support the development of a more paradoxical view of leadership that encourages greater leader behavioral and cognitive complexity as well as increased leader flexibility” (Lavine 2014, p.189). Earlier, O’Neill and Quinn (1993) reported that the CVF may be used as a tool for practising managers, helping them to comprehend complex leadership issues and situations. Thus, as shown in Figure 2.1, in this study, the CVF allowed for an exploration of the leadership experience of nurse and allied health middle managers, providing insight into middle managers’ training and leadership developmental needs, as characterised by their preparation for their role, effectiveness of training and improving professional development practices.

The literature described above has revealed important insights into the leadership experience of healthcare middle managers. This review has discussed 3 concepts of literature, which were relevant to exploring healthcare middle managers’ leadership experience in an acute healthcare setting, and the links between the 3 concepts and the CVF. The first has to do with the healthcare context itself. The second concerns the characteristics of the leadership perceptions of healthcare middle managers. The third literature has to do with the middle managers’ leadership training and development needs. This study sought to explore the congruence or otherwise between what is documented in this review, with that which healthcare middle managers perceived to experience in the context of MDH.

2.8 Methodological choices

In their review of current practices Stentz et al. (2012) recognised that quantitative research remains the most popular approach among leadership researchers. Participants in leadership research are normally asked to report on leadership using questionnaires and surveys. Alvesson and Sveningsson (2003b, p.364) however, argued that these particular procedures limit variation and standardise responses. They insisted that through such procedures “too much is assumed and there is a neglect of ambiguity” giving the false impression of objectivity. Nevertheless, most of the existent research on leadership and management has been descriptive and qualitative, particularly due to the sensitivity of the context and because of the points of view of those being studied (Bryman et al. 1996). In his assessment of the contribution of qualitative research to the study of leadership, Bryman (2004, p.762) gave an account of an increasing number of leadership studies that have been carried out using qualitative methodologies. These studies give “an aspect of leadership that has been difficult for quantitative researchers to gain access to”, in particular in gaining insights to the realities of leaders in particular contexts using leaders’ own words.

In reality, the literature is full of debates and controversies about the appropriate research methodology for studying leadership and management. Researchers suggested that due to the limitations of each type of methodology and the complex nature of leadership and management, the use of mixed methods may be advantageous (Stentz et al. 2012; Bryman 2004; Yukl 1989). In their review of current practices of research designs to leadership research, Stentz et al. (2012) likewise argued that broad multiple research approaches in the leadership research field are likely to better address the understanding of such a dynamic and complex phenomenon. However, more work has to be carried out to identify the relevance of mixed methods design in the advancement of leadership research. Further debates about the appropriate methodology for studying leadership have pointed towards studies designed to elicit narrative accounts (Yukl 1989). Scholars affirmed that narratives and stories may be used to make sense of ambiguous events (Hunter 1991), and also to make sense of complex experiences (Riessman 1993). Drawing on the work of various research studies, Lökman et al. (2011) elucidated that hospitals in particular “are rich grounds for collecting stories” (p.35) as they cut through the great complexities within hospitals. Moreover, narratives may better engage middle managers' own voices, help them to share personal experiences and interpret the practical implications of their own leadership realities (Bryman 2004; Currie and Brown 2003). Sims (2003) added that story-telling and experience are not separable. He explained that “[e]xperience is only made available through memory, when it is turned into a story” (p.1197). Meanwhile, Alvesson and Sköldberg (2000, cited by Alvesson and Sveningsson 2003b, p.379) maintained that more reflexivity is required in leadership research for a more critical, open and questioning approach.

Therefore for this study, a qualitative methodology offered the best opportunity to address the research questions. Participants were also encouraged to use narratives and stories. Interview questions designed to elicit narrative accounts are particularly appropriate for encompassing and understanding the complex interplay of contextual and wide array of factors affecting leadership, and the path between training and the leadership experience (Sims 2003). This indeed was the approach to data collection adopted in the research study being documented in this thesis.

2.9 Significance of the study

This literature was built around 3 interrelated concepts: healthcare context, middle managers' leadership perceptions, defined by middle managers' role, emotions and interpersonal relationships; and their leadership training and development needs, which were characterised by middle managers' preparation for their role, effectiveness of training and improving professional development practices. The study was informed by the CVF. The literature review provided insight into the complexity of the healthcare context, the competing tensions and demands of middle managers, and the leadership training and development needs of middle managers working within various settings, including healthcare. Table 2.1 summarises the main

articles included in the literature on healthcare leadership and middle managers, highlighting the gaps in knowledge that are relevant to the thesis.

Table 2.1 Main articles highlighting research on healthcare leadership and middle managers.

Study	Study Purpose	Context	Findings	Future Research
Procter, S., Currie, G. and Orme, H., 1999. The empowerment of middle managers in a community health trust: structure, responsibility and culture. <i>Personnel review</i> , 28(3), pp.242-257.	To determine the empowerment of middle managers in a community health trust	Community Healthcare Trust, UK NHS	<ul style="list-style-type: none"> - Some middle managers did not take up opportunities for empowerment - Middle managers worked in an uncertain environment - They perceived threats rather than opportunities in building their role - They perceived lack of support in management development 	- Research into the role, influence and involvement of the middle manager to the benefit of the organisation
Viitanen, E. and Konu, A., 2009. Leadership style profiles of middle-level managers in social and health care. <i>Leadership in health services</i> , 22(2), pp.108-120.	To examine leadership styles among middle-level managers in health and social care using the leadership role definitions developed by Robert Quinn et al.	Municipalities within a university hospital, Finland	<ul style="list-style-type: none"> - Leadership orientations were unrelated to the manager's age, work experience or management practice - Social and healthcare managers used several orientations to respond to organisational expectations, emphasising humanness, empathy, listening, willingness to help, collectivity and process orientation 	<ul style="list-style-type: none"> - Additional research on middle managers' leadership involving subordinates or superiors through personal interviews - More studies using Quinn's model in the social and health sector
Denis, J., Langley, A. and Rouleau, L., 2010. The practice of leadership in the messy world of organisations. <i>Leadership</i> , 6, pp.67-88.	To examine the leadership experiences in the context of the healthcare field as a practical activity, focusing particularly on its dynamic nature	Healthcare contexts, Canada	<ul style="list-style-type: none"> - When exercising leadership in large, complex and messy organisations, leaders need to see themselves embedded in networks that they do not fully control - Knowledge healthcare leaders gain through their day-to-day interactions and actions is an invaluable resource for learning 	- Further studies that capture the experience of doing leadership in complex organisations

Snell, A.J. and Dickson, G., 2011. Optimizing health care employees' newly learned leadership behaviors. <i>Leadership in health services</i> , 24(3), pp.183-195.	To gain an understanding of the workplace experiences of health professionals after taking leadership development programmes	Healthcare organisations, Canada	<ul style="list-style-type: none"> - Participants were enthusiastic for the uptake of leadership knowledge - Qualitative evidence of what supports and hinders employees in practicing newly learned leadership behaviours was identified. 	- Qualitative research that provides an overview of the workplace leadership experiences of individuals after taking leadership development programmes
Birken, S.A., Lee, S.D. and Weiner, B.J., 2012. Uncovering middle managers' role in healthcare innovation implementation. <i>Implementation science</i> , 7, pp.28.	To stimulate research that examines the contribution of middle managers in healthcare organisations to promote consistent, high quality innovation implementation	Discussion paper, US	<ul style="list-style-type: none"> - Middle managers diffuse information, synthesise information, mediate between strategy and day-to-day activities, and sell innovation implementation 	- Investigation of middle managers' influence to improve the effectiveness of healthcare innovation implementation
Buchanan, D.A., Denyer, D., Jaina, J., Kelliher, C., Moore, C., Parry, E. and Pilbeam, C., 2013. <i>How do they manage? A qualitative study of the realities of middle and front-line management work in health care</i> . Perth, Scotland: National Institute for Health Research.	To determine how middle management roles in acute care settings are changing, and the implications of these developments; how changes are managed following serious incidents; and how clinical and organisational outcomes are influenced by management practice	Healthcare Trusts, UK NHS	<ul style="list-style-type: none"> - Middle managers are deeply committed and highly motivated but have to cope with increasing demands and diminishing resources - Middle managers have a negative stereotype devaluing their contribution - The extensive, complex and constantly changing nature of acute trust management agendas appears to have adverse implications for stress and work-life balance - Most managers have little or no management training 	<ul style="list-style-type: none"> - To explore directly the roles, experiences, contributions and motives of middle managers in healthcare - To understand the implications of managerial jobs - Research into the applicability of high-reliability organisation perspectives in acute care settings
Melo, R.C., Silva, M.J. and Parreira, P., 2014. Effective leadership: competing values framework. <i>Procedia technology</i> [Online], 16. Available from: http://www.sciencedirect.com/science/article/pii/S2212017314002710 [Accessed 5 November 2016].	To identify the led nurses' perceptions of the performance of leadership roles by manager nurses	Health units belonging to institutions which authorised the study	<ul style="list-style-type: none"> - Nurses' perceptions are that manager nurses are competent - Need for nurse managers to promote cohesion and teamwork, and contribute to conflict resolution 	- The gap between actual and desired perceptions of leadership calls for future research into the leadership process occurring within a context of flexibility and the need to balance different roles creating more balanced leadership

From the literature reviewed it is evident that there is a considerable body of research on leadership and middle managers, yet little is known about the leadership experience and realities of hospital middle managers (Buchanan et al. 2013). Earlier, Procter et al. (1999) raised concerns that there has been a poverty of research focusing on middle managers within healthcare organisations. Furthermore, Birken et al. (2012) argued that although there are exhaustive studies on leadership, research on the experiences and contributions of healthcare middle managers working within complex and dynamic organisations are few and far between. Moreover, most of the research has not captured the experience of leadership of middle managers involved in complex settings (Denis et al. 2010). Similarly, Anthony et al. (2005) and Kahn (2005) asserted that although the important role healthcare leaders play in their workplace has been documented in the literature, little research has been undertaken to examine the work of healthcare leaders to better understand the experience, complexities and difficulties unique to their leadership role within healthcare settings. Reasons for this may be that healthcare middle managers are not a well-defined group, making the group difficult to identify (Buchanan et al. 2013). It is thus apparent from the literature reviewed that research on healthcare middle managers is not as decisive as researchers and scholars suggest. In addition, empirical evidence on the leadership experience and realities of healthcare middle managers from the nursing and allied health professions working in specific settings is meagre. Presently, there is a gap in the literature in this respect and there is a need to document leadership experience for mutual learning. Moreover, little qualitative research providing leadership experiences of healthcare employees after participating in leadership development programmes exists (Snell and Dickson 2001).

A number of other insights have emerged from the literature reviewed that are relevant for the understanding of the leadership experience of nurse and allied health professionals occupying middle management roles. It appears necessary for these middle managers in acute healthcare environments to understand the complex nature of their role. These individuals play a critical and crucial role within complex and acute healthcare settings, and so must be able to address future healthcare needs in a rapidly changing environment. The review shows evidence that healthcare middle managers would benefit from leadership development programmes.

Moreover, the leadership experience of nurse and allied health middle managers working in the principal acute general public hospital in Malta has not been previously studied. Hence, the proposed study will seek to draw inferences that reflect the subjective insights of middle managers for a more comprehensive account of this area of inquiry. This will contribute to knowledge and provide added relevance to health sector middle managers, senior managers, trainers and the health organisation through the integration of wellbeing and organisational

development in the local context, the ultimate aim being the improvement of health practice and patient-centred quality care.

Therefore, exploring the leadership experience of nurse and allied health middle managers was recognised as a priority and salient purpose for this research. The study sought to examine middle managers' own experience of practising leadership within the setting of a principal acute general hospital. Debates about the appropriate methodology for studying leadership strongly suggested asking questions that were designed to elicit stories and narrative accounts. In addition, qualitative approaches to inquiry and researcher reflexivity were uniquely suited to uncover the unexpected and discover new possibilities, simultaneously explaining contextual dimensions. The intended outcome was to provide insight and make recommendations to support and improve healthcare middle managers in their roles.

Thus, after organising and focusing the literature review, the theoretical model in Figure 2.1 was developed further. The theoretical model in Figure 2.3 provided the methodological basis for developing the study and for analysis of findings.

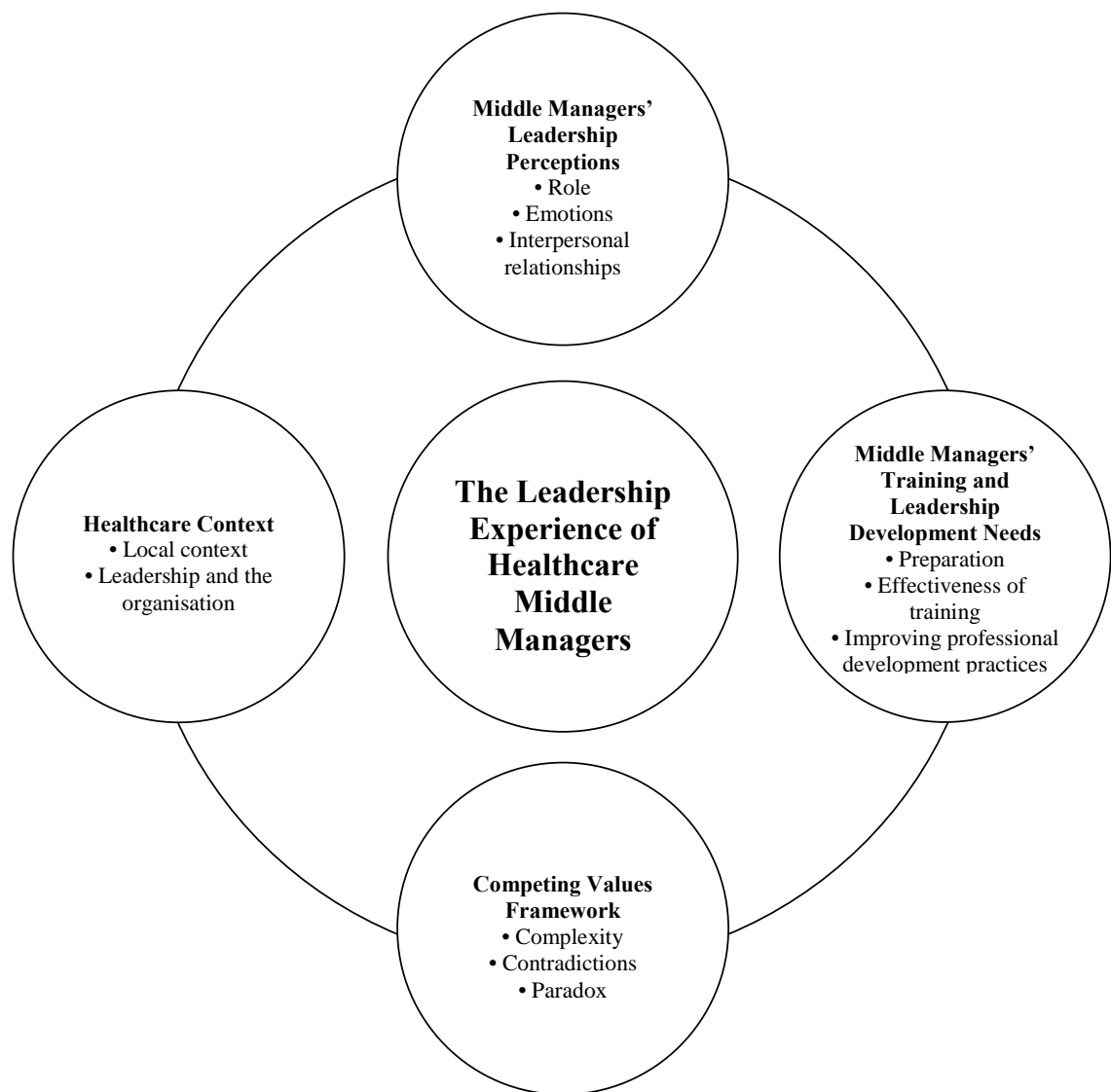


Figure 2.3: Theoretical model used in the research study. The model reflected a descriptive framework explaining the key concepts to be studied and the specific categories researched in this study. Leadership was explored against the Competing Values Framework background via the interview questions.

The 3 literature concepts within the theoretical model set the scene for the exploration of the leadership experience of nurse and allied health middle managers against the competing tensions within the CVF. The concepts were brought together in the following research questions:

1. What are the leadership perceptions of nurse and allied health middle managers in an acute public general hospital?
2. How do these middle managers describe the challenges that impacted on their abilities to lead within their organisation?
3. How can healthcare middle managers be better supported in their leadership training and development needs?

2.10 Conclusion

This chapter has explored the theory, research and practice of related literature. It has also summarised the gap existing in the literature about the research topic. The literature reviewed provided the context in which the study was set. It is the goal of my thesis to focus on the insights, concerns, views and perceptions of nurse and allied health middle managers, an often forgotten component of research studies on leadership. This qualitative study provides knowledge and gains further insight into how healthcare middle managers' lead inside an acute public health hospital, through an understanding of their leadership perceptions, developmental needs and training support essential for them in their leadership roles.

Moreover, the study focuses on an area which as yet remains unexplored in Malta. Insights into the perceptions of healthcare middle managers working in an acute healthcare setting were examined through the construction of participants' leadership experience. The research adds to the understanding of the specifics of middle management leadership in a complex health and professionalised context.

The next chapter outlines the research design including the philosophical assumptions, the methodological approach and the methods adopted to address the research questions.

Chapter 3 Research methodology

3.1 Introduction

In the previous chapter I situated the research questions guiding the study in the context of other research about healthcare leadership and middle managers, critically examined the existing literature, and simultaneously discussed the theoretical perspectives of the subject area. Literature suggests that healthcare is complex and as healthcare organisations tackle new challenges, more prominence is being placed on healthcare leadership. The literature posits that the role of healthcare middle managers is also complex. Hence, middle managers function within a health setting of paradox and competing demands requiring preparation and leadership development. Although considerable research has been done on leadership and leadership in healthcare, little is known of nurse and allied health middle managers' experience of practising leadership. To investigate this issue, the CVF informed the study. In view of this and the insights obtained from the literature review, this chapter describes the research design and the methods used for gaining an understanding of the leadership experience of nurse and allied health middle managers within the healthcare context of MDH. The aim and objectives of the study are presented together with the philosophical underpinnings underlying the research questions. The rigour enhancing the methodology is also discussed. Additionally, the research participants, recruitment, pilot work, data collection and thematic data analysis are described. Ethical issues are examined, recognising the tensions encountered in an open and critical way. The role of reflexivity throughout the research process is also discussed.

3.2 Research aim and objectives

Specifically the aim of the thesis was to capture to-date, non-existent, in-depth knowledge about the leadership experience of nurse and allied health middle managers working within MDH. The qualitative study intended to bridge the gap on the experience and contribution of healthcare middle managers working within complex and dynamic organisations. In addition, the study sought to increase the understanding of the practical implications of leadership for middle managers, in addressing the competing job demands and roles expected of them within their everyday organisational realities. By exploring middle managers' experience of leadership, the study intended to contribute to existing leadership knowledge from the perspectives of the middle managers themselves, and make recommendations towards the development of leadership practice in healthcare services.

On the basis of semi-structured interviews, an in-depth examination of the leadership experience of middle managers was sought so as to explore, describe and explain the participants' leadership experience. This approach had the advantage of studying middle managers'

leadership experience holistically and in the context of their setting. The study provided rich information from participants' accounts leading to knowledge explaining leadership in practice. Consequently it was possible to develop a description and deep understanding of middle managers' leadership issues.

The research objectives providing direction for this study were:

1. To explore the leadership perceptions of nurse and allied health middle managers in an acute public general hospital, as defined by their role, emotions and interpersonal relationships.
2. To gain insight into the leadership challenges of middle managers and how these influenced their leadership practice within their organisation.
3. To understand middle managers' perceptions on what training and development efforts may offer them an improved leadership experience in their roles.

3.3 Research design

Research is concerned with the nature and generation of knowledge. Paradigms provide a means of generating this knowledge by giving the direction for research and allowing focused research. This implies that the way that scientific knowledge is generated depends very much on the researcher's identification of epistemological, ontological and theoretical issues underpinning that particular paradigm. The nature of social reality and theory of knowledge will in turn have an impact on the research ideas, methodology and conclusions drawn, as these are the underpinnings and building blocks to research. In this section, the major research dimensions impacting how the research questions of this study were set will be discussed, namely the ontology, epistemology and theoretical perspectives (Denzin and Lincoln 2005).

The ontological perspective relating to the nature of leadership and underlying the research questions is constructionist (Bryman 2008). It is not something that can be measured objectively because the reality of leadership is not fixed. People's behaviours cannot be predicted. It is the nurse and allied health middle managers who construct their leadership experience. The reality underpinning the research questions is subjective, context-bound and based on the views and understandings constructed by participants, and these are very much based on their individual experiences and multiple interpretations which can change with time. I, as the researcher, achieved this by talking and listening to participants, and embracing their different realities, rather than detaching myself from them (Herbert 1990).

Scholars contended that leaders are continually influenced by the specific dynamics and interactions of the health organisational setting in which they function (Carroll *et al.* 2008). Hence, the epistemological stance was one that attempted to generate data and knowledge so as

to sensitise and understand the subjective and contextual reality of middle managers within the secondary healthcare setting of MDH (Knafl and Howard 1984).

The constructivist perspective of the leadership experience and the theoretical stance for studying leadership pointed towards qualitative methodology. The study used an exploratory design, with descriptive, interpretative and explanatory elements (Miles and Huberman 1994), albeit with narrative overtones (Sandelowski 2000). Participants' narrative accounts provided the possibility to explore their leadership experience beyond the boundaries of the interview questions (Overcash 2003). It is believed that perspectives are different for each person and this qualitative design enabled the researcher to explore and interpret how participants made meaningful sense of their leadership experience as perceived by them, within their healthcare context (Polgar and Thomas, 2008, p.85; p.249). Therefore, the qualitative research was carried out from an interpretivist point of view seeking to understand the perspective of the people being studied (Birchall 2014; Bryman 2008; DePoy and Gitlin 1994). It focused on the interpretation and the construction of meanings by middle managers, and the examination of their subjective reality in a meaningful way searching for significance, meanings and implications (Patton 2002). Therefore, the study conducted within a constructionist framework is closely linked to the theoretical perspective of interpretivism (Corbin and Strauss 2008). In fact, the interpretive paradigm proposes that reality may be socially constructed (Asif 2013). This emergence provided information through understanding and grasping the participants' experience of leadership. The data thus provided a rich description and deep understanding of leadership issues experienced by the middle managers participating in the research study, who all drew from one specific context, that is, an acute public general hospital in Malta. Generation and collection of data were also possible through my interaction with participants during the interviews, with the data being reflective of participants' reality.

Certainly, qualitative research has particular value as "a tool for extracting and understanding personal experiences and context" (Birchall 2014, p.15). Collins and Cooper (2014, p.89) maintained that "[q]ualitative inquiry is unique because it requires both emotional maturity and strong interpersonal skills to "collect data" or, more precisely, hear the stories of others and use their words to describe phenomena." Hence, the qualitative design enabled me to uncover how participants interpreted and made meaningful sense of their leadership experience. This was the principal aim of the study. Consequently, I obtained a "thick" description of the experience from the perspective of the people being studied (Ryan 1993, p.36). This is in contrast to positivist, quantitative research, which is an objective, formal and systematic process in which numerical data are collected and the relationship between variables tested by formulating a hypothesis (Ryan and Golden 2006). Its goal is generalisability and replicability as opposed to qualitative research, where it is not possible "to rigidly replicate qualitative research" (Birchall 2014, p.1).

Unlike quantitative data, qualitative data build on unique perceptions through meaningful conversations and this enriched the authenticity of middle managers' experience in this study. Qualitative research is ideally suited to discover meaning from leadership experience especially with regards to healthcare issues (Chandler et al. 2013). As individuals' experiences are shaped by the contextual conditions in which they interact daily, it can be argued that the value of these experiences are dependent on several factors, including the individuals' perceptions and interpretation of such perceptions (McCaskey 1991). Alternatively, quantitative research assumes that reality exists by itself and it can be explained using numerical data (Birchall 2014). Thus, a quantitative design was felt to be inappropriate for this study.

As the researcher, I acknowledged my own position within the research field derived from my previous research experience, professional background and experience. Barbour (2014, p.12) supported the assertion that a number of researchers have their favourite research methods with which they are familiar and hence, there is a match between the researcher and research methods. In fact, I favour research approaches where participants are encouraged to share their experiences. Indeed, "[r]esearchers are also positioned within the social world and their own life experiences and disciplinary socialization inevitably shape their approach to doing qualitative research – in terms of the questions they seek to address, the methods they employ and the methodological approaches they adopt" (p.15). Furthermore, Barbour (2014, p.25) reviewed the literature by other scholars and spoke about the "moral virtues" requiring qualitative researchers to be "knowledgeable; structuring; clear; gentle; sensitive; open; steering; critical; remembering; and interpreting." Indeed a tall order, but I did try to emulate these virtues throughout the research process.

3.4 Ethical considerations

The aim of the research was to help the understanding of leadership within the specifics of healthcare middle management in an acute healthcare setting. It also intended to contribute towards the enhancement of knowledge and development of leadership practice in healthcare services in Malta. In this regard, the research was of benefit to participants. Additionally, the study complied with the best practice of quality and ethical standards anticipating the impact on participants, and confidentiality with small sample sizes in a specific setting. Proper consideration was given to: participants' rights and well-being; participants' rights to confidentiality; privacy and anonymity; anticipated benefits to the participants and others; importance of resulting knowledge; continuous informed consent process; researcher's own beliefs and values; additional safeguards when research also considered other factors e.g. administrative matters in hospital and data protection provisions (Houghton et al. 2010; Polit and Hungler 1998; Behi and Nolan 1995).

All research information was recorded, handled and stored in a way that allowed its accurate reporting, interpretation and verification. Data protection clearance and institutional permission to access the research area for this study were obtained (Appendix II). Then, ethical consent was sought from the Research Ethics Approval Committee for Health (REACH), University of Bath, UK. Subsequently, since the actual research project was carried out in Malta, I presented the approval letter from REACH (Appendix III) and applied for ethical clearance to the University of Malta Research Ethics Committee (UREC), Malta, and the Office of the Data Protection Commissioner according to the stipulations of the Data Protection Act XXXI of 2002 (Chapter 440 of the Laws of Malta). The research protocol was approved by UREC (Appendix IV). The ethical principles and issues adhered to during the research will now be discussed.

3.4.1 Informed consent

Following authorisation to proceed with the research, an invitation of participation explaining the purpose of the study was sent to potential participants via an invitation letter (Appendix V). The study duration, location and anticipated procedures were explained. Completion and return of the invitation implied their consent to participate in the research and for the potential participants to be contacted again to arrange for an interview.

To improve participation, a number of steps were taken. Potential interviewees were provided with clear information about what the research involved. They were given the opportunity to withdraw from the study prior to the interview and before signing an informed consent form (Appendix VI). The interview questions were given to respondents one week prior to the interview so as to allow them the opportunity to consider their responses.

Participants were assured of data protection, anonymity and confidentiality and that no personal data would be attached to comments in the writing up of the report and future publications (Bowen 2005). After transcribing the interviews, a post-interview consent form (Appendix VII) was used. This helped to overcome the challenges encountered in maintaining data confidentiality in the study, which was carried out in a specific setting and involved a small number of participants (Kaiser 2009). The form ensured an ongoing informed consent process where the respondents' participation was voluntary throughout all stages of their participation (Polit and Hungler 1998).

3.4.2 Confidentiality and anonymity considerations

Confidentiality of records identifying the participants was maintained in compliance with data protection legislation. It was explained to participants that data would be safely stored on paper records and electronically until all information was collated, documented, reported and published up to a maximum of 5 years, as stipulated by the university. In order to safeguard

participants' anonymity, participants' names were replaced by codes, and thereafter represented by pseudonyms instead of their real names (Houghton et al. 2010; Wiles et al. 2008; Ford and Reutter 1990). Any information linking codes and pseudonyms to participants' names will also be destroyed after the 5 year period. Besides maintaining anonymity, pseudonyms portray better the human element of participants, as opposed to codes, which appear to reduce people to letters and numbers. The human element is key in qualitative research. In this study, each pseudonym and its first letter corresponded to the participant's gender and profession. This helped to differentiate between the two professional groups. Thus, pseudonyms starting with an 'N' were used for middle managers from within the nursing profession, whilst pseudonyms starting with an 'A' were assigned to middle managers from within the allied health professions. For example, the pseudonym 'Nadine' represents a female nurse, whilst 'Adam' represents a male professional from the allied health professions. Table 3.1 shows how participants' names were replaced by pseudonyms to hide their identity.

There are times however when confidentiality may be over-ridden to fulfil one's professional obligation (Mathers et al. 2000). In this research, participants were alerted that should events associated with malpractice or illegal activities become apparent during the interview, the promise of confidentiality did not hold, and the researcher held a professional obligation to report (Wiles et al. 2008). This information regarding the professional obligation to report was given to potential participants in the invitation letter.

It is acknowledged that since the small number of participants was recruited from a very specific and identified context, data may make the participants identifiable by those who know them (Tolich 2004). Deductive disclosure (Kaiser 2009) was a challenge I had to address. "Deductive disclosure, also known as internal confidentiality, occurs when the traits of individuals or groups make them identifiable in research reports" (Kaiser 2009, p.1632). Hence, acting in the participants' best interests, I continually sought to avoid putting the small sample of participants in a vulnerable position through an on-going informed consent process as recommended by Kaiser (2009). In addition, I ensured that whilst reporting accounts of middle managers' experiences, I protected their identity by taking extra care to ensure that they were not identified through their comments (Smith 1992), simultaneously maintaining the essence of the data (Kaiser 2009).

Moreover, participants were assured that no personal data would be disclosed in the writing-up of the report and future publications. Participants were also asked to provide additional feedback on how they preferred to have their data handled. After transcribing the interviews, I went back to the participants to give them the opportunity to go over the transcripts and verify if they were an accurate recording of what they had said. This was done before they were asked to sign the post-

interview consent form (Appendix VII). It is a risk that participants may remember what they meant in an interview but not what they said. They may also disown or discard the data after having reviewed it (Gerrish and Lacey 2010), because they may feel embarrassed and concerned with the content of the transcriptions (Houghton et al. 2010). Nevertheless, I did not experience such conservative behaviour from the interviewees and they did not request to rephrase or alter any of the data. However, there were 3 participants who requested parts of the interview not to be quoted in the published document, as these parts may have revealed their identities. I discarded these parts so as to ensure their anonymity and confidentiality (Ford and Reutter 1990).

Certainly, the post-interview consent form helped participants to re-consider their privacy after the data collection process. The extra cautious and two-step approach addressed anonymity and internal confidentiality, and did not put the small sample of participants working within the specific context of MDH in a vulnerable position. The post-interview consent form balanced risk and harm. Middle managers had much at stake when sharing their experiences and the post-interview consent gave them more control over the data, enhancing a participant-centred perspective (Hoskins and White 2013).

3.5 Population and sample

The study population was derived from middle managers from the nursing profession and from the professions falling under the remit of the allied healthcare services directorate according to inclusion and exclusion criteria. At the time of the study there were 10 nurse and 27 allied health middle managers providing services at MDH. In the local context, the allied healthcare professions include disciplines from the therapy, diagnostic, counselling and scientific professions, namely, audiology, clinical perfusion, dental hygiene, dental technology, dietetics, medical imaging (radiography), medical laboratory science, medical physics, occupational therapy, ophthalmic support (orthoptics, optometry), orthotics/prosthetics, physiological measurements, physiotherapy, podiatry, psychology, social work, and speech and language pathology. There is no accurate description of common characteristics that define the allied health group. In fact, allied health professions are neither defined by their commonalities, nor by boundaries that exclude other healthcare professions (Institute of Medicine 1989). For the purpose of this thesis, allied health professions were grouped together because they are distinct from nursing.

It is specifically the perceptions and leadership experience of nurse and allied health middle managers working at MDH that were sought. For the purposes of this thesis, the term healthcare middle manager encompassed hospital staff with a clinical background and with roles that included management and leadership responsibilities. Administrative middle management staff

working within MDH was excluded from the study because it is specifically the former who are directly linked to patient care outcomes, being key in enhancing safety and quality healthcare. Consequently, the invitation letter was sent to all middle managers from the allied health and nursing professions according to inclusion criteria. This was done to include maximum variation in perspectives. Middle managers from the allied health and nursing professions working within MDH and who had completed the leadership and management training programme offered by the employer were able to participate in the research. A general description of the training programme is found in Appendix VIII. In the course of the study, not all of the allied health disciplines provided services at MDH, and therefore, did not fit the inclusion criteria.

In essence, 10 middle managers from the nursing profession and 25 middle managers from the allied health professions fulfilled the eligibility criteria and hence, were invited to participate in the research. My aim was to interview about 20 middle managers. If more than 20 middle managers would have showed an interest to participate, I intended to use stratified selection so as to ensure that both professional groups would be more or less equally represented. Alternatively, if numbers were far below the 20, specific potential interviewees, again with stratified sampling purposes in mind, would have been approached for a second time. I planned to approach them in person to explain the purpose of the research and the importance of one's participation. However, this was unnecessary as 21 middle managers from 35 eligible middle managers accepted to participate in the study: 7 from the nursing profession and 14 from the allied health professions. Although stratified sampling was employed, I also used purposive sampling. I sought information-rich middle managers and I deliberately chose to invite all middle managers with particular characteristics non-randomly (Bowling 2009; Polgar and Thomas 2008; Morse 1991). Although the sample size was small, the number of participants was considered appropriate for researching the middle management group within the particular context of MDH, the main justification being that the whole population of nurse and allied health middle managers at MDH consisted of only 37 middle managers (Baker and Edwards 2012).

Additionally, there were 4 potential interviewees who were avoiding my telephone calls to set an appointment, even though they said that they were willing to participate. I could sense that their response, or lack of it, was indicating that they did not want to do the interview. Subsequently, I decided not to chase the potential participants any further. Certainly, the impact of non-responders may pose implications and sets the question whether the data generated provided unbiased results. Non-responders included both nurse and allied health middle managers. None of the non-responders provided a reason for their non-response. Unfortunately, further data on non-responders was unavailable. However, they did not appear to differ from responders in terms of participant characteristics. Boersma et al. (1997, p.1055) stated that

“[m]ost studies show that non-responders do not differ from responders in terms of sociodemographic characteristics.”

3.5.1 Participant characteristics

Participants were qualified individuals with academic and clinical backgrounds, and with past leadership experience primarily related to patient care. These individuals would have followed traditional career paths by serving as clinicians, gradually gaining experience in healthcare management, and progressing their way through the organisation so as to follow a career path taking them to higher management levels. They had varying degrees of leadership and management backgrounds in various healthcare specialties of different sizes.

Participants were situated in a unique position as they were sandwiched between the front-line clinicians and senior management (McConville and Holden 1999). Their overarching responsibilities varied depending on the number of staff members they were accountable for. However, general leadership and responsibilities were common. Participants were responsible for the management of the provision and delivery of services within specified clinical departments and units. They also supervised professionals who in turn lead teams of nursing and allied health professionals. Additionally, they were responsible for maintaining high quality care, effective day-to-day operations and timely attainment of task-related targets. During 2012, middle managers from the nursing profession were accountable for 1303 clinical staff and 230 support staff. Middle managers under the remit of the allied healthcare services directorate were accountable for 481 clinical staff and 41 support staff (N. Cuschieri, pers. comm., 6th February 2012). The sample of middle managers was made up of 10 men and 11 women. Their years within the service ranged from 9 years to 40 years, whilst years in their present position ranged from 6 months to 35 years.

Table 3.1 illustrates a summary of participants' characteristics. Data intentionally exclude the service that the individual allied health middle managers belonged to, and specific information regarding the education level for each interviewee. This was done to protect the anonymity of the small number of participants recruited from a specific and identified context.

Table 3.1: Summary of participants' characteristics. The table shows the gender, professional status, number of years in service and years in position, and the highest educational qualifications achieved by participants. Participants' names were represented by pseudonyms.

Pseudonym	Position	Years in service	Years in position
Noel	Nurse middle manager	27 years	3 years
Nicole	Nurse middle manager	40 years	6 years
Nadia	Nurse middle manager	20 years	2 years
Naomi	Nurse middle manager	30 years	2 years
Nancy	Nurse middle manager	34 years	5 years
Natasha	Nurse middle manager	28 years	2 years
Nadine	Nurse middle manager	29 years	2 years
Abigail	Allied health middle manager	36 years	35 years
Anna	Allied health middle manager	32 years	31 years
Adam	Allied health middle manager	9 years	8 years
Aaron	Allied health middle manager	20 years	7 years
Amanda	Allied health middle manager	27 years	13 years
Anthony	Allied health middle manager	27 years	7 years
Arthur	Allied health middle manager	15 years	3 years
Andrew	Allied health middle manager	30 years	3 years
Alex	Allied health middle manager	34 years	13 years
Amber	Allied health middle manager	31 years	14 years
Adrian	Allied health middle manager	32 years	10 years
Alan	Allied health middle manager	34 years	30 years
Abraham	Allied health middle manager	33 years	10 years
Amy	Allied health middle manager	20 years	6 months

Highest educational qualifications achieved

Post-graduate Diploma: 2

Master's Degree: 4

Doctoral Degree: 2

MSc Candidate: 1

PhD Candidates: 2

It is interesting to note that after having completed their formal professional education, all participants decided to further their personal educational aspirations in management and leadership training, obtaining a number of certifications in leadership and management. Moreover, 38% attained postgraduate academic qualifications. Besides, during this research study, 1 participant was enrolled in a master's programme and another 2 were enrolled in a doctoral programme.

Furthermore, middle managers from the nursing profession reported to the Chief Executive Officer (CEO) and the director for nursing and midwifery services at MDH. Similarly, allied health middle managers participating in the study were accountable to the CEO at MDH and the allied healthcare services director. However, the hierarchical reporting for middle managers belonging to the audiology, dental hygiene, dental technology, dietetics, ophthalmic support, medical imaging and medical laboratory science services was different as they also reported to their respective clinical chairmen. The latter are normally doctors or dentists in consultant positions.

3.6 Data collection methods

A semi-structured, face-to-face interview was thought to be appropriate for the research study so as to answer the research questions and to gain an understanding of leadership experience from an insider's perspective (Miller and Glassner 2011). Initially, focus groups were considered for gathering data for the two professional groups. Focus groups are very suitable for exploring data from respondents' perspectives, based on respondents' perceptions, attitudes and understanding (Fitzpatrick and Boulton 1994). However, I wanted participants to be able to express their innermost beliefs and perceptions freely. Nyamathi and Shuler (1990) observed that a disadvantage of focus group interviews is that some participants may be inhibited and influenced by the more active participants, forcing compliance of ideas and attitudes. Besides, the detail and complexity of an individual's perceptions are more likely to be drawn out from a one-to-one interview. Interviews may also give richer self-reported information about the participants' leadership perceptions, whilst the semi-structured component of the interview allows flexibility of topics (Barbour 2014; Bold 2012; Davies 2008). Gemignani (2014, p.131) defined the qualitative interview as a "relational event" extending "beyond data collection to allow the possibilities of the telling, the told, and the understood." Interviews also allow the interviewer to build a rapport with the participants. Consequently, it was deemed that interviews were the most suitable method for fulfilling the research aim. Yet, the interview is not a straightforward research technique as "discourses, emotions, subjectivities and identities come into play" (Lippke and Tanggaard 2014, p.137). It is indeed a tool that creates an artificial situation that intrudes on the interviewees, putting them under pressure (Myers and Newman 2007). Hence, it was important that I was as respectful as possible.

Interview questions (Appendix IX) were formulated consistent with the purpose and objectives of the study. The CVF was used to guide data collection as suggested by Sofaer (2002). The interview document consisted of 18 questions. I prepared a 'shadow document' for me to use during the actual interviews, which was used to guide the conversations, to ask questions in a consistent way with all participants and to go beyond surface responses. It helped me to check whether I was asking the right questions and whether the phrasing was sufficiently clear. I also

used headings so that I was able to guide the interviewees on leadership issues that were being discussed and elicit a broad range of responses.

Using the CVF to guide data collection was beneficial in mapping unique experiences and knowledge. Participants' implicit views hence became explicit and meaningful, forming a "cognitive representation" of the participants' world (McCaskey 1991, p.137). The CVF suggests that for leaders to be effective, they have to perform contradictory roles and fulfil competing expectations (Lawrence et al. 2009; Yang and Shao 1996). Additionally, Viitanen and Konu (2009) supported the notion that middle managers function within a context of complex, conflicting and contradictory expectations. Therefore, the interview questions were specifically developed against the CVF background to explore and understand middle managers' leadership experience within the acute healthcare context of MDH.

Furthermore, interview questions were linked to the concepts and categories illustrated in the theoretical model in Figure 2.3. This model was drawn from the 3 concepts discussed in the literature review, whilst the CVF formed the approach for this study. For instance, the first 4 questions reflected context and interviewees' perceptions of their leadership role. Interviewees' responses to these questions gave me insight into the local context of leadership and what interviewees' leadership perceptions within the particular context were. Questions 14 to 17 also provided an understanding of the respondents' work environment and their organisational challenges, as indicated in their perceptions of their leadership impact on quality healthcare and organisational development. These questions were linked with the first concept of the theoretical model.

Next, I wanted to explore middle managers' leadership perceptions of dealing with challenges that impacted on their abilities to lead within the organisation, and with addressing conflicting and contradictory demands associated with their role, emotions and interpersonal relationships. Thus, specific questions were asked as indicated in interview questions 5 to 9, and 14 to 17. These questions explored concept 2 of the theoretical model. The expectation was that respondents picked up issues around role ambiguity and role conflicts, hidden behind the set of interview questions, and that these would provide insight into the practical implications of leadership for middle managers, inherent in addressing the competing demands and roles expected of them within their everyday organisational realities.

Moreover, I sought participants' responses to training activities and their perceptions of leadership training and development needs, as represented in the third literature concept. These were described through respondents' preparation for their role, effectiveness of training and improving professional development practices. Interview questions 10 to 13 evaluated concept 3

of the theoretical model. Participants were encouraged throughout to relate critical incidents illustrating their experiences.

Interview questions were open-ended to allow participants freedom to respond from a variety of dimensions and to follow up important points. Care was taken not to confine participants' views to the CVF and retain flexibility in view of the participants' unique perceptions. I also used a technique whereby as the interview progressed and comfort level was reached, I returned to probe participants' earlier answers so as to corroborate their answers and to obtain a further picture. This resulted in a deeper and more reflexive conversation as participants were more eager to share their experiences. I now give an example of this strategy. Late in the interview, when the interviewee was relaxed, I returned to probe deeper his earlier answer:

Noel: One can be in a management position and not be fully conversant with leadership...as I told you, almost every single senior nurse we have are not university graduates...I still doubt whether academically they have enough knowledge on leadership and other related issues.

VA: Do you see this as a difficulty? Towards the beginning of this interview you mentioned the nursing aide. Though he was not academically brilliant, however he still showed he was a leader in particular situations.

Indeed, Riessman (1993, p.66) considered how "meanings of experiences shift as consciousness changes." Catterall and Maclaren (1997) offered further contribution to this position when discussing focus group data. They explained how "[p]articipants expand later on experiences recounted earlier; adding new information, giving the experience a new and sometimes different interpretation" (p.xxii). Hence, information given by the respondents and the emerging data were based on participants' beliefs and continuous interpretation.

All interviews took place in either the interviewee's office or a private conference room in MDH. In all instances the environment was comfortable and non-threatening to both the interviewees and the researcher alike. Interviews were recorded with a digital recorder. On average, the interviews took 56 minutes. During each interview, field notes, as well as personal reflections were taken, as recommended by Patton (2002). Additionally, a short profile of the interviewees was drawn up based on my interaction with them. The profile helped to contextualise the contents of the interviews, as the meanings of interviewees' statements depended on who said what, how and in what context.

Next, I engaged in a laborious process where I did a verbatim transcription of the data without including the subtleties of expression. Transcribed interviews and notes of participants' statements formed the data for the study. Transcription brought me closer to the data (Sandelowski 2000). To enhance methodological rigour, the transcripts were later returned to the interviewees for their approval and to verify if the transcripts were accurate recordings of what they had said (Houghton et al. 2010). It was important that the interviewees had the opportunity to ensure that the transcripts represented their experience. One interviewee made minor modifications which had no bearing on the research. All transcripts were eventually approved.

3.6.1 Role of the researcher

Any suggestion that researchers must be completely objective is absurd. It is difficult for researchers to remain unattached from the research in an interview process (Holstein and Gubrium 2011). Their opinions are never value-free but they are invested with theory-laden observation. Although scientific research seeks to be objective, it can never be as the researchers always influence the way fieldwork is carried out, how the data are gathered and the way that data are analysed. Equally, with qualitative research, the researchers' own orientations and values cannot be excluded from the way the data are interpreted, because much of the researchers' thinking is based on preconceived ideas that have been acquired through social and environmental influences rather than objective truth (Lippmann 2010).

At the outset, so as to minimise bias, it was important for me to situate myself in the research, as well as identify the relationship between myself and the research (Birchall 2014; Creswell 2009). Doing insider research, I was in a unique position in relation to the participants (Greene 2014). As a middle manager working within the same organisation as the participants, I realised that I was unable to be completely detached from the research (Davies 2008; Field 1991). I was not coming into the study with no knowledge and pre-conceptions. I was bringing to the research setting my own beliefs, values and assumptions about leadership, and my own experiences, challenges and successes as a leader (Bold 2012; Fontana and Frey 2005). I had also read the literature. I was therefore aware that my assumptions and beliefs may have diverged from those of the participants, and so I had to go beyond my own leadership experience in order to seek the participants' meanings (Creswell 2009). This argument is reflected in what Lippke and Tanggaard (2014) identified as a "tension field" (p.136) between the researcher and the participants. These scholars revealed that "muddy interviews" are "an inevitable aspect of the researcher's identity negotiations and emotions in the research process" (p.136).

Certainly, my own orientations and values could not be excluded from the way I interpreted the data. Holstein and Gubrium (2011) asserted that the interview is open to interpretative practice, although obvious biases that support the researcher's beliefs should be avoided (Barbour 2014; Squire et al. 2013). Moreover, Delamont (2002, p.8, cited by Weiner-Levy and Popper-Giveon 2013, p.2177) insisted that the researcher "should not waste time trying to eliminate "investigator effects"", but should instead "concentrate on *understanding* those effects." Therefore, I found that my own experience, insight, knowledge and even feelings were useful resources in analysing and interpreting the data. As a fellow professional with knowledge of the local setting, I was therefore able to draw inferences from the data. In this study, my role and influence on the study were elucidated through reflexivity (Weiner-Levy and Popper-Giveon 2013). Reflexivity will be explored in more detail in section 3.9.

3.6.2 Pilot work

The interview schedule and analysis procedure were piloted with 2 middle managers from the allied health professions and 1 middle manager from the nursing profession. These interviewees were selected at random, being as representative as possible of the full set of interviewees. Pilot testing considered the wording and sequencing of questions, and potential probing questions to ask. It was during these interviews that I understood what probes to use to elicit the information required and at which point to ask them. In addition, the pilot interviews helped me to critique the interview process and become familiar with the interviewing role, and gain familiarity with the questioning and analysis routes (van Teijlingen and Hundley 2001).

Next, analysis of the pilot interviews was discussed with the research supervisors. The supervisors critically reviewed the transcripts and the interpretation of codes and themes (Hale *et al.* 2008). Analysis of any differences was then made. This enhanced credibility of the data and determined the reliability of the coding. The pilot interviews were subsequently included in the 21 interviews of the main study. van Teijlingen and Hundley (2001) expressed concern when pilot data are included in the main results, as data inaccuracy may result when modifications to the pilot interviews are made. However, in this study, the interviews followed the same line of inquiry as the pilot interviews. In fact, although the questions were refined, no major changes were effected to the interview questions, and hence the pilot data were considered to be of value.

3.7 Data analysis

Thematic analysis was conducted following Braun and Clarke's (2006) guidelines of data analysis in a number of systematic and interrelated steps (Appendix X). Thematic analysis is a process of identifying patterns or themes within the data. The 6 phases of thematic analysis used to analyse the data included familiarity with the data, generating initial codes, searching for

themes, reviewing the themes, and defining and naming the themes. The phases of thematic analysis will now be described.

3.7.1 Familiarity with the data

I listened carefully to the audio recordings. I read the transcripts and then listened again to the recordings whilst re-reading the transcripts. Transcribing all the interviews myself helped me to re-live the interview experience, as well as stay close to the data (Patton 2002). This also had its analytical benefits in terms of encouraging me to start identifying key labels. Next, I organised the transcripts into documents with margins on the right hand side. Whilst analysing the transcripts, I highlighted parts of the text that seemed important. Subsequently, I inserted comments in the margins for each highlighted part of the text. I also used additional memos and sticky notes to capture my thoughts on the importance, relevance and interpretations of the data. This is recommended by Saldaña (2013) when managing small research projects. In working with the data, I also identified tension points when the respondents ventured outside their comfort zones. I paid particular attention to similarities, differences, contradictions, non-conforming data and any exceptions to findings.

3.7.2 Generating initial codes

Following that, I engaged in a challenging process where descriptive codes identifying interesting features in the data were generated. Coding is a way to label different pieces of data according to its meaning. Appendices XI to XIV contain examples of initial stages of coding. Coding helped to stimulate my thinking and keep track of the data (Bazeley 2013). Interview data were initially coded using the theoretical model, the literature and the research questions. However, in the course of analysis, with renewed reflection and as new ideas emerged and were explored, I modified, clarified and expanded the codes. Therefore, analysis was both “analyst-driven” or deductive, and inductive (Braun and Clarke 2006, p.84). Peredaryenko and Krauss (2013) referred to this “continuum of states” as an “inductive-deductive dichotomy” (p.11). In fact, Dey (1993) asserted that when using semi-structured interviews with open-ended questions, not all themes can be anticipated in advance of data analysis. On the contrary, some themes may be emergent (Bazeley 2009; Creswell 2009).

In qualitative research, computer software may be used to assist the coding process. Fielding and Lee (1998) argued that CAQDAS (Computer Assisted Qualitative Data Analysis Software) helps in organising the data and maintains a record of the researcher’s decisions. Hence, it enhances the rigour of the analysis, especially when dealing with large data sets (Trochim and Donnelly 2008; Seale 2005). However, I opted to use traditional manual methods using colour coded highlights, memos and comments on the margins of the text. Manual coding together with the interview transcriptions, field notes and reflections helped me to stay as close to the

data as possible. Software creates distance. Likewise, Saldaña (2013) maintained that traditional analysis techniques may give the researcher “more control over and ownership of the work” (p.26). Additionally, a computer programme cannot substitute the researcher’s intuition when identifying codes and themes within the data (Ryan and Bernard 2013). Neither is it an alternative to the creativity and richness of the analytical process (Corbin and Strauss 2008; Seale 2005). Moreover, computer programmes cannot replace the researcher’s role in interpreting and extracting meaning from the data. It is these aspects of analysis that enhanced the quality of this qualitative research.

Bryman (2008) highlighted two common criticisms of coding qualitative research, namely the fragmentation of data and taking the text out of context. Moreover, Roller (2010) pointed out that qualitative researchers must embrace the “tangles” and “messiness” of qualitative data analysis. I tried to overcome these challenges by following Saldaña’s (2013) recommendation that the researcher should keep focused by referring to the research questions, aim and objectives of the study, as well as the theoretical model and its components. Some questions that I considered during coding were:

- What is out of place or self-contradictory?
- What are the points of tension and irregularities?
- Are there any patterns?
- Are there similarities and differences in the participants’ responses?

3.7.3 Searching for, reviewing and defining themes

Whilst remaining close to and immersed in the data, I revised my codes and coded and re-coded the data, going over the transcripts several times. I maintained a reflexive approach and used the personal field notes and analytic memos. A master list of codes was created (Appendix XV). At this stage I also highlighted data extracts that could be related to codes. Codes were then grouped together to form broader potential themes and sub-themes. “A theme is a grouping of ideas or meanings which emerge consistently in the text” and is important in relation to the research questions (Polgar and Thomas 2008, p.248). Dominant themes were refined to produce a final list related to the coded extracts and the entire data set, ensuring that the themes reflected the interviewees’ points of view, their perceptions and my interpretations. Flip charts were used to produce a “thematic ‘map’” showing evidence of the different themes and the relationship between them (Braun and Clarke 2006, p.89). The themes were refined further to check whether the defined themes covered all aspects of the data and cohered around the central research question. Data extracts were selected and allocated to particular themes so as to reveal meaning from the raw data. Three primary themes and 12 sub-themes, providing an in-depth description

supporting each theme were derived (Appendix XVI). The themes and sub-themes were related to the key concepts within the theoretical model used in the research study.

Qualitative data analysis is certainly not a linear process. Throughout this iterative process and as I unpacked the leadership perceptions of healthcare middle managers, I modified the codes and themes as my understanding of the data evolved. I continually referred back to the audio recordings, interview transcripts and field notes to stay closer to the original meanings and contexts, keeping in mind the overarching research question. Moreover, I took a reflexive approach throughout data collection and analysis. Validation of themes was performed by referring back to the original transcripts.

3.7.4 Interpreting the themes

At this point, I returned to the research questions and the theoretical model supporting the research questions. Data were further examined, “challenged, extended, supported and linked in order to reveal their full value” (Bazeley 2009, p.8). The key themes and sub-themes were brought together into an explanatory framework, and related back to the research questions and the theoretical model, consequently constructing a cogent story of the leadership experience of healthcare middle managers. Drawing on the ongoing analysis of the 3 key themes and 12 sub-themes, 4 major findings were generated. These findings are presented in chapter 4. Appendix XVII contains a sample description of the themes, significant quotes and their meanings, which supported the representativeness of the themes and from which the findings were derived. Quotes provided an understanding of how healthcare middle managers experienced leadership.

3.8 Issues of trustworthiness

Qualitative research is more appropriately assessed by trustworthiness rather than through the conventional reliability and validity measures used in quantitative research (Koch 2006; Guba and Lincoln 1981). Guba and Lincoln’s (1981) criteria to define trustworthiness will be borrowed so as to capture concerns in qualitative research, namely credibility, transferability, dependability and confirmability. Procedures that helped ensure trustworthiness will also be outlined.

3.8.1 Credibility

Credibility is said to exist when the researcher is confident that the findings of the research study represent as near as possible the true picture of reality regarding the phenomenon under investigation (Guba and Lincoln 1981). In qualitative inquiry the researcher as the research instrument, remains central to credibility. Interviewer bias may pose a threat to neutrality or objectivity of the research (Roller 2014; Soin and Scheytt 2006). The researcher may interject personal beliefs on to the participants that may influence and shape the respondents’ answers. In

addition, Merriam et al. (2001, p.411) argued that when researchers are conducting research in one's work area, they are "frequently accused of being inherently biased" as they are unable to "raise provocative questions." Nonetheless, it is believed that in view of the significant methodological rigour, middle managers' description of experiences provided a representation of their leadership experience realities, simultaneously "honouring" their voices (Chandler et al. 2013, p.1). The interviews indeed developed into "repositories of accumulated wisdom" (Brown and Duguid 1991, p.45).

Credibility was further enhanced through purposive selection of participants for their expertise and experience (Liamputtong 2011). Hence, interviewees became "constructors of experiential information" (Holstein and Gubrium 2011, p.151). Gemignani (2014, p.132) similarly described the construction of research participants' reality as the "creation of knowledge and re-finding of forgotten things." Consequently, in order to enhance credibility of the results, during the interviews I intentionally probed and searched for ways so that participants had the opportunity to define, give a sense of worth and make potential valuable experiences visible. Gemignani (2014) explained that "in the moment in which the interviewer asks about one's experience, the past is being written by the participant through the interviewer's presence, style, sensitivity, and social constructions, which occur in the unique interview context and historical time" (p.134). This was kept in mind throughout the analysis and interpretation of the data.

In addition, after transcribing the interviews, I went back to the participants so that they could go over the transcripts and verify if they were accurate recordings of what they had said. This reinforced trustworthiness of data. I also used participants' quotes in the presentation of research findings in order to emphasise and honour middle managers' own voices, and to share their experiences "as generative of meaning and knowledge" (Chandler et al. 2013, p.2). This will give an opportunity to readers to "experience a connectedness to the participants' stories" (Chandler et al. 2013, p.4).

In the subsequent analysis process, validation of codes and themes was performed by referring back to the original transcripts, the interview questions and the field notes. Keeping field notes was helpful in reflexive data collection and analysis. Besides, interviewees' profiles documented after each interview also helped me to maintain a reflexive stance. Complex situations of role conflict may in fact be alleviated if the researcher maintains a stance through self-reflection and critical analysis (Houghton et al. 2010; Hand 2003). This transparent research process added credibility to the study, and to the reporting and interpretation of findings (Carolan 2003).

3.8.2 Transferability

Transferability refers to the extent to which the data are relevant to other settings or groups (Polit and Hungler 1998). Transferability was enhanced by grasping an accurate and detailed description of participants' points of view. However, fittingness of the data rather than generalisability is likely to be appropriate in such a research scenario (Appleton 1995). Additionally, to add the degree of applicability to other similar groups of participants and work settings, it was ensured that research participants were identified and described accurately. Information about the characteristics of the research setting was also given.

In order to assess the degree of transferability, the researcher needs to ensure that the decision trail of the research is clear and comprehensive. The decision trail process was devised by Sandelowski (1986). It involves the researcher describing thoroughly the methodology used and the method of data analysis that may be followed by other researchers. It was ensured that the decision trail of the study provided the means through which decisions taken about the theoretical, methodological and analytic choices were explicitly explained. In fact, Koch (2006) argued that whoever is reading the research report should be able to examine the "decisions taken about the theoretical, methodological and analytic choices throughout the study" (p.92), as well as any biases that could have influenced the researcher.

3.8.3 Dependability

Dependability is considered as the equivalent of reliability in quantitative research. It is also very much linked with the notion of the decision trail and credibility of the findings. Robson (1993) stated that a qualitative research study that establishes credibility will also be dependable.

Three of the interviews were also a pilot test procedure. This helped to increase interviewer dependability or degree of consistency. Minor adjustments made to the interview further increased the consistency of the data collected. The audio recorder used to record the interviews, and the field notes, also enhanced dependability. Moreover, the degree of consistency of analysis was enhanced since I conducted and transcribed all the interviews myself. This helped me to remain close to the data, and provided me with a unique opportunity to critique and improve on successive interviews. Such in-depth coverage contributed to proper research practices and dependability.

3.8.4 Confirmability

Confirmability entails that the data are linked to their sources, and that conclusions and interpretations emanate directly from them (Guba and Lincoln 1981). Hence, the findings must reflect the result of the research, and not the outcome of the biases and perceptions of the

researcher. Aware of this, I tried to achieve confirmability by maintaining a balanced stance between my own position as a middle manager and my simultaneous position as a researcher. However, Hammersley & Atkinson (2007) pointed out that the researcher is in fact part of the social world under investigation, and the researcher's personal characteristics and knowledge become an integral part of the research. Moreover, Saldaña (2013, p.39) argued that since individuals "most likely perceive the social world differently, we will therefore experience it differently, interpret it differently, document it differently, code it differently, analyze it differently, and write about it differently." Consequently, reflexivity was employed during data collection and analysis to examine this interaction between myself and participants. In fact, reflexivity is a critical component of qualitative research as a method of enhancing rigour, validity and confirmability (Birchall 2014; Greene 2014).

Additionally, triangulation was used as an additional strategy to support completeness of findings (Miles and Huberman 1994). Triangulation allowed for the use of different methods of collecting data so as not to rely on one single source of data, and thus avoid personal biases. Data from the transcripts were checked against the field notes. Moreover, researcher reflexivity provided a more complete understanding of the area being explored (Williamson 2005; Morse 1991; Denzin 1989). Field notes corroborated respondents' perceptions, whilst reflexivity added my own perspective to the interpretation of the leadership experience of middle managers. Reflexivity also ensured that I continuously checked my research assumptions and remained focused on the data (Birchall 2014). Despite this, one cannot overlook the reality that no phenomenon is ever complete (Sandelowski 1995). Mathison (1988) raised awareness regarding the value of triangulation. She claimed that triangulation provides evidence that can be "convergent, inconsistent or contradictory" (p.15), and so researchers still have to construct their own explanations about the phenomenon being studied. Nonetheless, triangulation of data methods in this study enhanced a broader picture, completeness, provided research rigour and revealed the possibly varied dimensions of what was being explored (Fenech Adami and Kiger 2005; Williamson 2005).

3.9 Reflexivity

In this study reflexivity was employed as a critical component of vigilance so as to refine the research process. The practice of reflexivity, a tool to avoid potential bias, is of particular importance to the qualitative researcher (Greene 2014). Schwandt (2001, cited by Collins and Cooper 2014, p.90) described reflexivity in qualitative research as the "process of critical self-reflection on one's biases, theoretical predispositions, preferences." He claimed that the researcher is part of the context he or she is seeking to understand, helping to make the implicit explicit. Moreover, Peredaryenko and Krauss (2013) described the reflexivity experience as a "calibration process" (p.2), a process in which the researcher's assumptions are kept in check so

as not to interfere with the experiences being studied. Additionally, Hale et al. (2007, p.143) advocated that “open reflexive reporting” of one’s assumptions, beliefs, values and experiences helps to produce “a valuable insight” into data reporting and interpretation. Along similar lines, Birchall (2014) and Roller (2014) argued that because of inadvertent researcher biases, preconceptions and prejudices, personal reflection is an important part of the research design. Alternatively, lack of reflexivity may affect the researcher’s listening in a way that “unconsciously filters, dismisses, or colours essential data” (Eliot 2014).

In this study, reflexivity on self and role were important in questioning perceptions, helping me to deal with professional discretion, uncertainty and ethical practice (D’Cruz et al. 2007). Reflexivity made me aware of how my leadership experience as an insider sharing characteristics of the middle management role, and my own knowledge, beliefs and understanding of the context, may have shaped my interaction with the interview participants and influenced the research. Indeed, although I was part of the culture under study, I may have been unaware and not have had adequate understanding of the sub-cultures of the participants coming from the various professions, other than my own (Dwyer and Buckle 2009). Albeit having a mixture of insider-outsider perspectives, I believed that reflexivity was the right approach because of my tacit knowledge of the area of practice, and also because I had established relationships with the healthcare middle managers involved in the research. Paechter (2013) argued that the methods to be adopted in insider research are centred on observation and “engaged listening” (p.74), with the researcher remaining key to the research process. This meant that I had to remain aware of what it was like to experience leadership in a middle management role, simultaneously distancing myself from the phenomenon being studied. Throughout the research I needed to consider how my own norms and assumptions, values and beliefs might bias my interpretations. This was a challenge due to my dual responsibilities as a researcher and as a middle manager. Through a continuing openness to reflection, I was able to internalise a new level of theoretical knowledge, leading to further reflection (Kolb 1984).

Furthermore, in their review of the literature, Collins and Cooper (2010) highlighted the benefits of emotional reflexivity in delving deeper into participants’ experiences, thus strengthening the validity of the research. Spencer (2010) emphasised that emotional reflexivity is “a very intricate process, and places serious demands upon the fieldworker to know themselves” (p.32). This is key in humanising fieldwork “through challenging the desire for certainty or a definite truth” (Collins and Cooper 2014, p.91). Hence, I used emotional reflexivity as an additional tool in managing relationships with the participants and in spontaneous decision making that was required during the fieldwork. This is particularly crucial when the researcher is the only data collection instrument. Therefore, at the outset, I had to ascertain my own emotions and my

emotional connections within the research field so that bias was minimised both during the actual interviews, as well as during the analysis and interpretation of findings.

3.10 Conclusion

In this chapter, I described the qualitative methodology that was used to research the leadership experience of nurse and allied health middle managers: rationale for qualitative research design; the research aim and objectives; population and selection of participants; methods of data collection; methods and procedures for data analysis; and issues of trustworthiness. I also showed how the interview questions connected to the theoretical model created from the concepts discussed in the literature. Moreover, I underlined ethical principles and issues, and the importance of reflexivity.

In the next chapter I highlight the research findings. I use participants' stories, narrative accounts and experiences, from which I extract quotes to illustrate middle managers' perceptions and explanation of their leadership experience. This will help to shape the discussion.

Chapter 4 Findings

4.1 Introduction

This chapter presents the research findings from the semi-structured interviews with 21 nurse and allied health middle managers. Interview data and field notes provided a rich, in-depth description of the leadership experience of middle managers working within the acute healthcare setting of MDH. The chapter begins with a restatement of the research aim and research questions, and details the reporting and explanation of the results. The aim of this study was to explore, describe and explain the leadership experience of nurse and allied health middle managers working in an acute healthcare setting. The exploratory study design with descriptive, interpretative and explanatory elements was guided by the following research questions:

1. What are the leadership perceptions of nurse and allied health middle managers in an acute public general hospital?
2. How do these middle managers describe the challenges that impacted on their abilities to lead within their organisation?
3. How can healthcare middle managers be better supported in their leadership training and development needs?

Data gathered through semi-structured interviews with the nurse and allied healthcare middle managers were coded and then grouped together into potential themes, utilising the 6 phases of Braun and Clarke's (2006) data analysis method. Analysis of the interview transcripts led to the identification of 3 primary inter-related themes and 12 sub-themes, which I felt best described the voices of middle managers, and which were consistent amongst the participants. These themes were considered to be a priori since the thematic categories corresponded to the interview questions, and hence, the themes were not unanticipated. Exemplar quotes from participants, selected on the basis of their representativeness, were used to describe and illustrate each theme. Some data extracts were also translated and presented in tabular form to summarise information. Nonetheless, non-conforming data were also included to show variability in the data and to provide a more complete picture of the leadership experience of participants.

The themes and sub-themes described participants' responses regarding their leadership perceptions, challenges, and training and development needs. These themes related to the theoretical model referred to in the literature review chapter, which included the 3 key concepts namely, healthcare context, middle managers' leadership perceptions, and middle managers' training and leadership development needs, and the CVF. The 3 identified primary themes

were: leadership perceptions, organisational challenges inherent in the healthcare context, and leadership training and development, as illustrated in Figure 4.1 below.



Figure 4.1: The primary themes and sub-themes identified from the data. The 12 sub-themes provided an in-depth description supporting each theme, constructing an explanatory model of the leadership experience of healthcare middle managers.

These themes and sub-themes set the foundation for the generation of 4 salient findings, constructing an explanatory and comprehensive model of the leadership experience of nurse and allied health middle managers. This model is illustrated towards the end of this chapter. The themes and sub-themes will now be presented.

4.2 Theme one: middle managers' leadership perceptions

Participants expressed a similar picture of their leadership perceptions. Their understanding of leadership was described in a number of ways and revealed through 4 sub-themes: meaning of leadership, leadership qualities, factors promoting and hindering leadership practice, and range of emotions.

4.2.1 Meaning of leadership

Overall, this sub-theme expressed nurse and allied health middle managers' views of their meaning of leadership. They mainly identified leadership as relating to others, organisational development, caring for employees and patients, influencing staff, respecting their views and knowledge, and empowering them despite the difficulties and obstacles. Table 4.1 summarises what leadership meant for participants.

A large part of how participants perceived their meaning of leadership involved relations and interactions with staff members. Leadership was seen as an influential and an interacting activity. Anthony described leadership as "taking credit together." Amber said that it was about

“striving to achieve a common goal.” Nancy explained that it “must be attained with people and through people.” Participants explained that staff recognition and giving value to staff experience and expertise were paramount towards collaboration and sharing the ownership of the credit. Leadership was also giving employees the necessary space where they could exercise their initiatives. Abigail remarked: “Leadership is about creating a vacuum in which other people grow into. You lead but you create a vacuum and people fill it...moving forward and leaving a wake behind you like a ship and people coming into it.”

Table 4.1: Summary of what leadership meant for participants.

- | |
|---|
| <ul style="list-style-type: none"> • Relating to others • Clear goals • Visibility and challenging the status quo • Focus on team/organisational interests and needs • Recognising staff efforts • Stimulating work • Striking a balance during everyday work practices • Being caring and supportive • Opportunity for learning |
|---|

Most participants highlighted the inter-relatedness of leaders and followers. Amy explained how she did not want to be judged by staff as being aloof or deserting her team: “At the end of the day I’m still one of them and I try to remain as such...There’s no distinction, I just have a different role. We’re a team of people but somebody has to lead.”

Nurse and allied health middle managers also spoke about visibility and being at the core of activities. Likewise, leadership was about challenging the status quo, developing staff and managing performance. These were 2 of the participants’ responses:

Arthur: Leadership means that I am always within reach to push forward innovations, to improve practice.

Nadine: I’m always trying to be present in the areas I’m responsible for. I’m always on the go. I don’t stop...I give feedback to staff.

Besides, participants viewed leadership as a learning opportunity. Alex spoke about leadership in relation to gaining knowledge and “always learning.” Adam explained how leadership was about acknowledging knowledge and qualities in others, and creating a learning organisation

through information sharing and a dyadic exchange of learning and teaching. Noel described leadership as a “learning experience.”

Meanwhile, most participants emphasised the importance of organisational development as another key function of leadership. They highlighted the promotion of collective, organisational ends, rather than their own interests. Participants referred to middle managers exercising leadership as members within a network of professionals, as opposed to being individual actors. Abigail said: “It’s not a single-handed thing that you do but being part of it. That’s something quite marvellous.” Indeed, Gabriel (2015b, p.322) claimed that “[c]are ethics grows out of people acting, not as sovereign individual actors, but as members of communities and networks that require constant effort and nurturing to sustain.” Likewise, Adrian expressed the need to understand the “big picture” and encouraging collaboration and networking: “I have to look at the big picture...if everybody minds his own little niche, we won’t get anywhere...the end result of leadership should be improvement of the whole organisation.” Similarly, Noel explained that middle managers required a broader and deeper understanding of “the big picture of leadership” so as to “have the insight of the situation...people, characters are all different so you have to adapt and lead particular people according to particular situations needing flexibility and adaptability and being in control” thus fulfilling paradoxical expectations.

Furthermore, caring was viewed as a basis for leadership. Middle managers practising an ethic of care evoked respect and admiration. Participants conveyed that a caring leader listened to staff but they were also aware that staff needs were not always consistent with the needs of the organisation. This required negotiating agreement and commitment with employees. Nancy remarked that “when you empathise with staff and you show appreciation, staff will recognise you for it.” Most middle managers shared similar thoughts. Equally, they were conscious that they had to align their leadership to the organisation, and highlighted the balancing of responsibilities. Participants offered explanations:

Naomi: At the end of the day you have to take note of the organisational goals. I work with the organisation but to be able to reach them you have to have the staff cooperating with you...so you have to find the balance.

Natasha: You have to be loyal to both the organisation and the staff members. To *both*. You have to be honest with staff and tell them what can be done within the remit of the organisation and what cannot be done...People may not like it but at least they’ll know that I’m being honest.

Similarly, Amy described how she attempted to strike a fair balance between showing care and concern for staff, and challenging staff: “I believe that you also have to be just and fair with everybody...So I may praise a person but I can also admonish that person. It depends on the situation.”

Moreover, participants reflected on the realities of leadership. Leadership was described as perseverance through buffering perceived workplace constraints. These are some revealing quotes shared by participants:

Abigail: I think we all start off in our careers thinking that we can do everything for everybody all the time and do it marvelously. Reality usually hits you when you realise that no, you don't have the answer to everything.

Nadia: You have to persevere...I think we've done audits since 2008. I mean, now, this year, we did it again. It was a joy but the first time, I had people slam doors in my face, I had people swear at me, I had people not talk to me because they thought that my aim was to mar their reputation, when my aim was to improve the care...sometimes you feel like going home, you feel like I lost the battle. Then you start all over again.

In this sub-theme, participants shared their insights, joy and frustrations of their leadership perceptions. Leadership was described as an excellent avenue for sharing tacit knowledge. Nurse and allied health middle managers explained their contribution to organisational development, leading change and transformation. Moreover, leadership was described as promoting collective, organisational ends, rather than middle managers' own interests. Leadership was about expectations and influencing others. It was also about finding the right balance and exercising cautiousness, loyalty and tact in their everyday work realities. Despite difficulties and obstacles, participants showed concern and care for their employees. They also empowered and facilitated employees so as to stimulate their commitment.

4.2.2 Leadership qualities

This sub-theme emerged from participants' descriptions of their leadership perceptions. Most nurse and allied health middle managers explained how leadership was a fine line between trust and vulnerability. Their responses revealed humility and sensitivity to staff needs, but also, confidence, security and emotional awareness. Table 4.2 highlights the main leadership qualities revealed by middle managers. Examples of participants' significant statements included:

Nadia: I listen to staff and give them a pat on the back when they need it and tell them to go home when they need it and tell them it's okay...I know how to say I'm sorry if I do something wrong or if I lose it.

Anna: I have found that when you have communication and persuasion...and you act in a transparent manner, you get trust and you get people to do whatever needs to be done.

Abigail: If you are in the position of a leader then the responsibility is huge and you've got to be humble enough to know that you don't know it all and know when to ask for help...being self-aware also helps you to understand other people.

Table 4.2: Leadership qualities revealed by middle managers.

- | |
|--|
| <ul style="list-style-type: none"> • Manifesting humility • Showing sensitivity to staff needs • Exuding confidence, security and emotional awareness • Integrating contradictory leadership characteristics • Empowering staff • Encouraging teamwork • Being a role model • Showing commitment to the profession • Being consistent and transparent • Possessing good communication skills |
|--|

Furthermore, participants cited integrating seemingly contradictory qualities. Nancy commented: "As a leader you may have to change from being democratic for example, to being bureaucratic. Yes, I do feel that it's somewhat contradictory because I prefer to exercise democracy and to discuss with the individual...I think it's tough but you *have* to do it...Those are very stressful situations." Similarly, middle managers brought attention to the courage required of them to offer support and motivate staff irrespective of the difficult situations encountered. Nancy continued: "Let's face it; our workplace isn't one of the most glamorous ones. We face problems and so you have to create that something to motivate staff, to help retain staff within the workplace and to progress in their career and in spite of all the problems you face, you are able to help staff find their niche in which they may find their own satisfaction."

Moreover, many participants mentioned empowering one's staff and encouraging teamwork as additional leadership qualities. Alan spoke about "motivation" and the "ability to influence."

This is how another allied health middle manager and nurse middle manager described their influence on staff:

Amanda: A leader has to be flexible, can listen, has the ability to get everybody on board with their own ideas...You can't lead, you know, on your own. You require the support of the people around you.

Natasha: We have to support each other within the team. I give staff the example of a table supported on 4 legs. If you're one of the table's legs and you're not giving your support, the table is unable to stand. So you have to give your own bit so that the burden is shared by everybody.

Others used phrases such as being a "role model" and a "source of inspiration to staff", showing "commitment to the profession", "consistency and transparency", and "communication skills." Amber and Alex described persuasion, responding to staff needs and treating them equally and fairly as important leadership qualities. Naomi identified having "guts and stamina, assertiveness and courage" when fulfilling workplace responsibilities. She also described how her role could put a strain on her home-life. Naomi perceived drawing a boundary between work and private life as an additional leadership quality: "Sometimes when I go home, I continue with the same train of thought and my son tells me – you're not at work here, you're at home. Go out and come in again so that you realise that you're actually at home. I do it sometimes and it helps. It's true, it helps."

In this sub-theme, participants mentioned several leadership qualities. Their responses revealed that participants' leadership qualities forged better relationships with staff members. They also underlined the value of the ability to strike a balance when they encountered competing tensions in their work.

4.2.3 Factors promoting and hindering leadership practice

Middle managers articulated a variety of satisfying and challenging aspects of their leadership perceptions that either promoted or hindered their leadership practice. Despite encountering a number of challenges, the majority of participants simultaneously expressed a sense of pride and optimism in their leadership experience.

Participants described areas of satisfaction that promoted positive feelings and gave them a sense of purpose. Common aspects included their indirect intervention with patients and their families, mentoring staff, and appreciation and recognition. Table 4.3 lists the most satisfying

aspects of participants' leadership role. This is how some middle managers shared these attributes:

Nadine: I am proud when patients are being given the right care. I feel proud that I made a difference by transmitting the right messages to staff.

Natasha: You feel *really* proud when you have a newly promoted nursing officer and you guide him, you mentor him, you empower him and then you see that he's really moving on. You receive good feedback about him from patients, relatives, carers and even from higher management.

Table 4.3: Most satisfying aspects of leadership role. These aspects promoted positive feelings and gave participants a sense of purpose.

- | |
|---|
| <ul style="list-style-type: none">• Well cared for patients• Ability to influence practice and service provision• Engagement and development of staff• Opportunity to mentor staff• Ability to support staff• Appreciation and recognition |
|---|

Appreciation and recognition of the efforts being made were proud moments linked to self-worth. Leadership satisfaction also meant being of service to staff members and a supporting presence in moments of need. Alex explained that “when you have a person coming to you with a problem, you’d want to help them, and that gives you satisfaction.” Natasha added: “When you gather round a table and you’d know that these are truly professional people and you manage to discuss with them in a mature manner. These are the day to day satisfactions. And the respect from staff as well. What you give is what you get. And you receive a lot in return.”

Alternatively, when discussing the challenging aspects that hindered their leadership practice, most middle managers identified lack of quality healthcare and conflict management as the most burdensome responsibilities. The most challenging aspects of their role are found in Table 4.4.

Table 4.4: Most challenging aspects of leadership role. These aspects hindered participants' leadership practice.

- Lack of quality healthcare
- Conflict management
- Dealing effectively with staff
- Inadequate staffing
- Limited control over workplace situations

For example, Nadine said that she was “kept awake at night when staff has not addressed patients’ needs” and feared “near misses a lot.” Other middle managers added:

Nancy: It’s conflicts between staff and even conflicts with the higher management. That’s a huge concern. Or else conflicts with other professions.

Amy: Dealing with different personalities. It’s the human aspect. Only those things keep me awake at night...when you have to deal with the human aspect of staff, that’s very difficult...when you’re dealing with people, very often it takes a lot and a lot of work.

Additionally, middle managers gave examples of lack of situational power and control. Natasha and Abigail described their disappointment when they worked hard for changes to happen and these did not materialise:

Natasha: You feel disappointed when you work hard for something and it never happens, when you’ve worked hard to alter a situation and this doesn’t change.

Abigail: We still have staff who let us down...and not being able to find solutions, effective solutions. Is it a question of my leadership, have I failed there? Yes I do feel disappointed.

Participants described the difficulty experienced in challenging the status quo. Amy’s narration showed how such a situation made her anxious: “It is very difficult...there are people who have got used to working in certain ways and this has been going on for years. It’s not easy to ask these people to change their ways. They look at things through their own personal aspect. They don’t care about the overall picture. It’s about me and what’s in it for me...it doesn’t suit them to change.”

Moreover, inadequate staffing levels were a sore point. Yet, participants demonstrated leadership qualities by hiding their own feelings of uncertainty and outwardly displaying positivity so as to positively influence staff and quality care. Nancy shared her experience of this: “The demand is always on the increase whilst human resources are always on the decrease, and that creates a lot of stress on our own management as well as our own staff...but by being there, with the staff, empathising with them, showing them that you’re caring for them, you try to convince them through these means. You have to be very tactful.”

For this sub-theme, nurse and allied health middle managers presented similar viewpoints. The factors that participants claimed to promote and hinder their leadership practice were all emotionally-laden. Participants expressed feelings of self-worth and professionalism, but also of fear, anxiety, disappointment and frustration, demonstrating the conflicting emotional demands experienced by middle managers when exercising leadership.

4.2.4 Range of emotions

In this fourth sub-theme, emotions played a critical role in middle managers’ leadership perceptions. Participants revealed a range of emotions varying from helplessness, anxiety and anger, to survivorship, joy and care, as seen in Table 4.5.

Table 4.5: Range of emotions expressed by participants.

- | |
|--|
| <ul style="list-style-type: none"> • Stress • Caring and compassion • Insecurity • Anxiety • Anger • Joy • Helplessness |
|--|

Negative emotional reactions were linked to factors hindering the leadership practice of participants. Middle managers felt that the healthcare context was complex and provoked feelings of “disillusion” and “indifference.” Nicole described the “endurance” required within the acute healthcare setting: “There’s a lot of stress here and so you have to have the endurance to be able to manage that...I feel tired, very tired...I end up literally drained.”

Most participants expressed caring and compassion. These were important leadership values and behaviours, central to working within a healthcare organisation. Middle managers treated staff with care and respect as if trying to protect them from the anxieties generated by the healthcare system. Through recognition of care, participants highlighted the importance of

attentiveness, empathy, responsiveness and responsibility for others. Examples of their statements included:

Aaron: I respect my colleagues and I love them to an extent.

Natasha: When you see that your staff is bearing the brunt of the decisions being taken, you have to emphasise on them. You have to show them that you understand their situation.

However, many nurse and allied health middle managers recalled the stress, insecurity and internal conflicts they experienced when managing employees who were not willing to collaborate and also, when dealing with senior management. They described situations that aroused strong, mixed and uncomfortable emotions. For some, assertiveness was almost a cause of embarrassment. Nadia and Arthur described their anxiety and insecurity:

Nadia: I was at a cross road whether I should resign because I had my superiors completely against me...I asked for mediation and they did it. But it took me two weeks of crying every day...I was desperate.

Arthur: I don't feel comfortable with my own self in certain decisions...I may take time to reach a decision; I procrastinate and start wondering whether I should take the decision or not take it at all. I'll be disappointed with myself because a leader should take a decision...For example, somebody who's not delivering has been appointed in one of the posts. How can you really address this person? You try to involve the person, you try, but he is not delivering...and that's where I feel that I'm failing.

Equally, middle managers reflected on circumstances that ended up in undesirable situations. For example, Noel and Adrian confessed a 'failure' on their part. This generated feelings of disappointment, but also demonstrated fallible leadership:

Noel: There was this patient programme that I believed should be stepped up, very, very much...but there are priorities at this point. So I feel like I failed.

Adrian: I had a problem with a staff member...it started off with an issue at work but then it became a personal matter. I realised that this person went behind my back to relate what had happened to another person, and when I realised what had happened, I was somewhat aggressive. If it happened now, I would have reacted differently...if I had done things differently, our relationship wouldn't be as strained as it is now and I

would have been proud that I managed to rise above the situation. But I didn't see it that way then.

Likewise, Anna disclosed an uncomfortable experience with a staff member that evoked several emotions. Her recollection was clearly something of a burden for her as she retrospectively sought to make sense of a painful incident: "I got caught up in a situation where I had to issue an admonishment to a particular person and I kept hoping that maybe we'd be able to communicate...this person went out on long sick leave and eventually he resigned...sometimes I don't feel proud of this because I say to myself, did it have to come to that? I feel I failed with this person.....I do feel a bit guilty because maybe there was another way in which I could have handled him. It could have been different; maybe there were other things I could have done; whether I was justified in what I had done. But it's how I saw the situation at that time. But *definitely* I don't feel proud about it."

Finally, participants expressed vulnerability and insecurity about their performance. They cited unrecognised contribution for their work and yearned to be empowered to share their opinions. Alan expressed the need for gratification and desire for recognition: "It's difficult when nobody rarely acknowledges the results."

Notwithstanding these negative emotions, participants also revealed positive emotional events that enriched their leadership perceptions and helped them to survive difficult situations. These were related to factors helping participants to exercise leadership, and were mainly reflected through recognition, delivery of quality healthcare and teamwork. The following excerpts reveal participants' feelings:

Naomi: When I reach the target, when I reach my aim, my objective and that of the team and we reach that. And then we can say, we did this together...that is something that gives me a lot of satisfaction...that gives me the joy of work.

Nancy: For me this is what gives me most satisfaction, that I see the patient getting what he needs and what is right and that we also take care of relatives through the staff.

Amanda: The fact that you form part of and participate in teams that are recognised by the hospital, and the hospital recognises that you're giving your contribution, yes you'd feel proud...you do feel proud in these circumstances even though you may have not managed the patient yourself but it motivates the team even more and you feel good about it.

In this sub-theme, participants' leadership perceptions provided an opportunity for the expression of positive and negative emotions that helped to shape their experiences. Emotions were defined by workplace events and issues, and relationships that were important to the middle managers. The healthcare context itself was seen to raise a number of challenges for middle managers, provoking various emotional reactions.

4.2.5 Summary: theme one

Each and every middle manager portrayed one's own personality and approach to one's leadership experience, and expressed perceptions differently. Having said this, irrespective of the profession, varying levels of education and the number of years as a middle manager, participants shared many similarities in which they described leadership, leadership qualities, challenging and satisfying aspects of leadership, and the range of emotions experienced. All participants had one's own story to tell. They all talked of moving through various conflicting and complex routes, hampered by obstacles and constraints. Hence, participants sought to balance responsibilities within their role. It is not surprising that this provoked emotional reactions. Caring and compassion were central to middle managers' emotions, mainly defined by working through employees, and giving them space so that they could grow. Key strategies mentioned by participants for harnessing collective energy, passion and creativity of their workforce were collaboration and interactions. Positive emotions emanating from such networking were the main sources of motivation for middle managers in their roles.

4.3 Theme two: organisational challenges

This second theme identified 5 sub-themes namely, caught in the middle, leadership impact, dealing with challenges, support and hindrances, and quality care and delivery. These sub-themes offered insight into organisational characteristics inherent within the healthcare context, which influenced healthcare middle managers' leadership experience, and gained an understanding of the work environment of nurse and allied health middle managers.

4.3.1 Caught in the middle

Participants broadly explained the organisational bureaucracy and brought attention to the hierarchical structure. This influenced their roles and relationships within the organisation. Participants captured the common sentiment that very often they were caught in the middle between their own staff, patient needs and senior management. Thus, they often had to seek to accommodate diverse demands. Moreover, participants reflected on the complexity, lack of clarity and relevance of their middle management roles, which very often provoked emotional reactions. The data in Table 4.6 outline the difficulties encountered with the middle management role.

Table 4.6: Difficulties with middle management role. These influenced participants' roles and their relationships within the organisation.

- Caught in between staff, patient needs and senior management
- Seeking to accommodate and balance diverse demands
- Lack of recognition and involvement by senior management
- Feeling undermined by own staff
- Perceived lack of control and authority within the organisation
- Unclear role expectations

Nurse and allied health middle managers' "squeezed" position created feelings of helplessness and frustration as they attempted to balance contradictory demands. This is how they transmitted their thoughts:

Nicole: Of course I feel squeezed. You feel squeezed between your superior and the needs of the areas, and the staff you're accountable for. But there's nothing you can do. You just have to bear it.

Andrew: Management will put demands, alright? Then there is the pressure by the clients and at the same time you have the staff. So you have to find a balance.

Many participants cited the perceived lack of recognition and involvement by senior management. Natasha, for instance, expressed her desired needs for self-worth, autonomy and control: "This is about my direct superiors. Meetings are held with my staff and you have to discover the outcome on your own. I won't even be involved...this creates bad feelings. So then you start asking – where do I stand? Is my position important? Is it relevant? Let me give you an example. When new nurses were recruited, I went to the wards and I just found them there...It's an obstacle for exercising leadership. We have to work in these conditions and you try your best under the circumstances. So then, you try to lick your own wounds because this really affects me and you try to move on."

Middle managers corroborated this view, adding that sometimes they also felt "undermined" by their own staff members. They expressed anxiety as they sought a balance between flexibility and maintaining control. Nadine said: "I'm always being bypassed. This is always happening in our position...I feel that I'm not being trusted...this is breaking me down."

Notwithstanding their perceived lack of control and authority within the organisation, participants highlighted that rather than feeling antagonised, they preferred to remain optimistic when dealing with workplace issues, and tried "to look at things through senior management's

eyes.” Abigail added: “I think experience teaches you to know when to put up a fight and when not to put up a fight...there are times when you know you have absolutely no control whatsoever and then what experience teaches you is how to accept that graciously without any bitterness, knowing that fine, I’ve been given this order. It may not be the way I may have done things but I just have to get on with it. It’s pointless becoming resentful.”

Additionally, participants found the integration of leader and follower roles to be a challenging venture. Accounts of role conflicts and dilemmas emerged repeatedly in the data. Participants reflected on how they dealt with their role complexities and unclear role expectations. They conveyed that whenever they felt “sandwiched in between” they tried to negotiate their way around. When Naomi was appointed to her position she “was very disappointed”: “I had different expectations to what I should be doing...I was disappointed because I found myself as a sandwich between higher management and staff...but then the job is what you make it...then you learn how to negotiate and this is where leadership skills come in – how good you are at persuading people to change their ways. There were times I managed. Other times I didn’t.”

Abigail reflected further: “Being squeezed, we also have to understand it’s the people we’re responsible for will also push us right to the very limit...one of the biggest skills that middle managers must have is self-preservation. They must look after themselves because they are in a very vulnerable position, *extremely* vulnerable and one of the risks of vulnerability is that you lose control because like they say, people will find your Achilles’ heel and they use that, yes?”

This sub-theme provided participants’ perceptions of the dynamics and organisational challenges of the middle management position, which involved leading others as well as being led by others. Being caught in the middle brought with it emotional reactions of being torn in between multiple and often competing needs, demands and concerns, and hence, confusion and lack of clarity within participants’ roles. This hindered participants’ leadership practice. Consequently, middle managers struggled to absorb the effects of stressors, so as to achieve a balance across ambiguous situations.

4.3.2 Leadership impact

Most participants described experiences of being of indirect influence to patient care and service delivery through empowerment and encouragement of staff. They hence contributed to quality healthcare within the organisation. Middle managers gave examples of how their leadership impact strengthened their motivations and evoked positive emotions.

Abigail explained how she felt about her leadership impact: “I think we all would like to take credit for changes that have taken place but it’s not like that...you may actually influence change by influencing the behaviour of people around you, which in itself will bring about

changes alright? It's a cascade, and that's where the pride of leadership comes...you'd like to be able to attribute all the good things to yourself but it's not like that, you know? But you know that you've been a part of it. Somewhere along the line you know that you've contributed to it."

When recalling their leadership impact, participants shared innovations that they had introduced and eagerly mentioned the tiniest milestones achieved, which made them feel proud of their contribution. They continually sought opportunities for change. This is how Anthony described his leadership influence: "There were small changes, very small and they won't show up but they're there. They're not visible...it's a change I contributed in...it was my initiative."

Yet, participants also voiced concerns regarding lack of support from senior management for initiatives and innovations. They struggled between their goodwill to effect change and their leadership impact. Alan conveyed how these situations promoted feelings of helplessness and frustration: "There were changes that I wished we could introduce as a service because the services we have provided have changed very, very little...they weren't supported by the head of department...I have tried speaking to him several times. I have tried other avenues by approaching other people but it didn't work."

Meanwhile, Nadine revealed how she felt out of place since her promotion to the middle management position. She felt unique in her previous role and now experienced disconnection from decision-making. Capturing the sentiment of most participants, she expressed her frustrations caused by lack of control, involvement and support by senior management. She attributed her feelings of uncertainty due to "lack of preparation and training." Moreover, Nadine desired recognition and hence, preferred to focus on the strengths of past experiences. She described her role as an act: "I'm feeling a disaster. I could go back to being a nursing officer. It's much more rewarding...I don't feel myself. It's as if I have put on a dress and now I've got used to it. As a nursing officer, I was more in control of situations...I knew what was going on...I knew my staff members and up to a certain extent, I was able to control the conduct of staff because you'd know what's going on all the time."

Consequently, Nadine experienced feelings of inadequacy. During the interview she exposed insecurity and questioned her leadership impact within the organisation. Yet, being told she was doing a good job was very supportive for her: "There was a patient in the corridor and I think I must have asked somebody to do something. And the patient said – *she is a good leader*...he was blind. He wasn't seeing me. He had just heard what I had said. That's what he said – *she is a good leader*. I stopped and asked him – are you referring to me? Of course, it's about you.....and you know, sort of, I continued reflecting on what he had told me and reflecting on

what I do...even now, you're referring to me as a leader and I'm asking myself – why am I a leader? How do I lead?"

Participants in this study voiced positive feelings associated with their leadership impact. Simultaneously, nurse and allied health middle managers struggled between their goodwill to effect changes, desire for recognition and low support. Senior management clearly influenced middle managers' leadership impact. An important point was made by 1 participant, describing her middle management role as an act, thus expressing insecurity about her performance. Training was also required to support career development and commitment to position. Furthermore, it was not surprising that these perceived constraints ignited emotional reactions within participants.

4.3.3 Dealing with challenges

This third sub-theme was derived from participants' perceptions of dealing with organisational challenges, as shown in Table 4.7. The following paragraphs represent middle managers' descriptions of their leadership perceptions and the workplace challenges encountered.

Table 4.7: Middle managers' perceptions of dealing with organisational challenges.

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|--|
| <ul style="list-style-type: none">• Conforming to expectations from senior managers and subordinates• Holding back from staff exposure to adversity• Owning and embracing change• Finding the right balance in an unpredictable environment |
|--|

Middle managers struggled to conform to expectations from senior management and subordinates, whilst maintaining the confidence and competence to earn and keep trust from both ends. Such situations evoked strong emotions as participants appeared to play a tightrope game. Abigail summed up the responses of most nurse and allied health middle managers: "I can say, fine, I've been ordered to do this, it's a direction that I've been given and that in itself means that there's no room for negotiation...that's the reality. So even if I don't agree with what is being said, the first thing I have to do is to accept it as gracefully as possible. Because the last thing you want to do is to be passing on that directive and running down the person who gave it to you...that is the hardest bit...you will understand what reaction you are going to get and you can find as many ways as possible to make it sound and be as positive as possible *without* offending your own staff, like treating them like idiots. You know staff is not stupid."

Anna conveyed similar thoughts but additionally highlighted how she held back from staff exposure to adversity: "I opt to be sincere with staff members. I do say that this is the way that my superiors are seeing this and that they may be seeing a larger picture to the one I'm

seeing...then I get really frustrated when they *do not* know the big picture...But then I won't pass on my disappointment to staff members. You'll have to carry that."

Equally, participants described their experience of owning and embracing organisational change, and seeing the possibilities in the change, rather than the problems:

Amanda: Sometimes because the organisation is moving in that direction, you have to seek what's good in it and try to move in that direction as well.

Naomi: The organisation sets a direction I don't agree with...that's very, very difficult...If staff don't own the change, it will not work. So it's better to encourage staff to own the change...and you always try to find the good things in the change.

Furthermore, participants disclosed how the healthcare context they worked in had complex implications requiring them to use flexibility and adaptability, finding the right balance, and negotiating their way to make things work. Amanda shared her experience of working within a complex system, commenting that "working in an acute hospital is not the easiest place to work in." Abigail reflected further on this: "I think what you learn as a leader is how to deal with diversities."

Participants also complained that their leadership impact was limited because they were made to feel that their professional opinion did not matter. Implicit in their narratives was that they expected their own superiors to be competent, just as they expected their staff to be competent. This provoked feelings of resentment and worthlessness. Nadia described this: "I found it very hard because seniors don't allow you to take initiative. Here you have to go through *so much* red tape that when you get approval, you forget about the project...I found this position very restrictive." Aaron described how he felt intimidated by his superior: "I'm also accountable for health and safety here. There is an emergency exit door that people used to go out through when they got out to smoke. There was a report that this door was being kept open. We closed it and attached a note to it, indicating that the door should not be used because it's an emergency door. When one of our top people returned from leave, he saw this note and tore it apart. He then phoned me to ask what this was all about. Then he told me that he used this door in the morning to get in to work. Don't do these things when I'm on leave because if the door is locked I won't be able to come in. I felt my legs trembling. Why am I unable to take certain decisions that I'm supposed to be taking? Why have I been put in this position? Is it because I'm capable or is it because they did not have anybody else, so they chose me? You reflect on this and you feel more stressed."

For this sub-theme, the overwhelming majority of nurse and allied health middle managers described how it felt to deal with the expectations of senior management and concurrently, the expectations of subordinates. Participants shared their anxieties of working in an unpredictable environment, and the tensions experienced when they felt unsupported and intimidated by superiors. These challenges hindered participants' leadership practice.

4.3.4 Support and hindrances

Nurse and allied health middle managers were split on the support or lack of support they experienced within their organisation. Besides, the dynamics of the various experiences described appeared to be very much linked with the organisational support or lack of it. Low support and understanding from senior management resulted in participants experiencing frustration and anxiety. Alternatively, when supported by senior management, they felt that their experience and expertise were being recognised and valued. Table 4.8 shows the factors that supported and hindered participants in their leadership experience.

Table 4.8: The factors that supported and hindered participants in their leadership practice in the workplace.

Support	Hindrances
<ul style="list-style-type: none"> • Support from senior management • Supportive peers • Networking 	<ul style="list-style-type: none"> • Lack of guidance and protection from seniors • Negative behaviour and lack of support from peers • Unrecognised contribution

In fact, support from senior management was one example of an anxiety decreasing safety network. Support promoted feelings of self-worth. Alan explained how this made him feel: “I feel proud when I am supported by my superior and things have moved, for example, improvement in services, the possibility of providing more courses and training for my staff...I feel good about it.”

However, participants acknowledged moments of disappointment when they were not supported, explaining how they had to cope with their own anxieties. They shared strong and meaningful statements that suggested lack of guidance and protection from their seniors. Nadine said that she felt “like a nobody” when her superiors did not acknowledge her efforts. Aaron expressed his utter disgust when his work and decisions were not appreciated. Anthony was ridiculed by his management when he took an initiative: “They poked fun at me...I find blank

faces and I really feel gutted.” Nicole offered an explanation for the lack of support: “I feel I do need support but I don’t find it....Sometimes it’s a problem of time; sometimes senior management is not available when you need them; and partly it’s that sometimes they do not understand you. It could be that they’re stressed as well.”

There was a notable difference in the way nurse and allied health middle managers shared their experiences on peer support. A number of nurse middle managers encountered negative behaviour and lack of support from peers, resulting in participants experiencing frustration. For example, Nadine yearned for honesty and openness within her work environment: “I feel that in my present situation, I’m being backstabbed all the time...as a group [referring to her colleagues] we don’t get on well together. You can’t be honest and say the truth...unfortunately we are working in silos.”

Allied health middle managers were generally more optimistic and confident about concerns being dealt with amongst peers. They revealed how a network of support amongst allied health middle managers had encouraged the group’s feelings of self-worth, underlining the importance of collaboration and support versus maintaining silos. They explained how contact with peers was helpful because it developed their learning, offered emotional support, and created trust and group cohesion. Gabriel (2015b, p.323) suggested that “all people are embedded in different webs of social relations, being dependent on others for their survival and well-being and capable of supporting others in their moments of need and helplessness.” This is how Andrew described the positive experience: “We shared experiences in that group. If I’m encountering some sort of difficulties, probably you’ll be sharing the same problems. You may have found a way of tackling a difficulty within your own department. We can share ideas. I realise that in my problems, it’s not just me. Everybody may have similar problems. You see, that was support to me...it was a fantastic experience...it also helped me to understand other professions better...we had a role, we were respected by hospital management.”

A number of nurse middle managers shared a similar positive experience from a nursing point of view. They sought support from colleagues and direct superiors, who often shared similar concerns. Natasha remarked that the opportunity to openly discuss concerns and reflect on situations with colleagues was in itself a learning experience: “We have the Monday meetings with our director. We discuss pertinent issues and then we’re given the time to say how we’re feeling. Sometimes you think that you’re on your own and that’s when you really feel lost. When you realise that you’re not alone, and also that others may have sought different solutions, there you will learn a lot.”

This sub-theme showed that participants' responses regarding support and hindrances varied significantly. A number of participants struggled with lack of support. This caused a lot of anxieties and hindered their leadership practice. Often, participants had to find ways to cope with their anxieties so as to maintain their self-preservation. Other participants reported positive experiences. Their responses reflected their experience on using networking in a process of reflection and learning, and critiquing their own assumptions. This presented them with alternatives to traditional ways of knowing and acting, and underlined the importance of networking versus maintaining silos.

4.3.5 Quality care and delivery

The fifth sub-theme provided participants' views of quality care and delivery within the organisation. When asked to illustrate good quality healthcare, the majority of nurse and allied health middle managers chose to speak about direct clinical care, focusing on patients' interests and needs, and supporting staff needs.

Most participants gave examples of personalised patient care, describing accounts of their roles, which kept them close to frontline patient care. They expressed genuine concern for patients and demonstrated passion for their work. Proud moments that enhanced quality healthcare promoted feelings of self-worth. Certainly, good quality care and delivery were judged based on the care provision for patients. The following quotes were the responses shared by 2 participants:

Nadine: The patient comes first and foremost...caring is the utmost. It's about the care...I am *very proud* of my staff. When you see a patient come in, in a very bad state and he is managed well and then he is transferred to a ward...I feel very proud of that.

Anthony: Quality healthcare is when you put the patient at the centre of your care, of your attention.

Conversely, participants expressed disappointment when substandard clinical provision was provided. They illustrated a healthcare system, which was sometimes indifferent, impersonal and routine. Moreover, participants felt powerless because at times they were not supported in their efforts and were left to deal with mistakes in the system on their own. Naomi narrated a situation where she conveyed her disappointment with quality care: "Medication errors do happen and they are not reported...I am extremely disappointed and I am worried...staff doesn't speak up if something goes wrong. This can have big, adverse effects. I just don't understand." Furthermore, middle managers revealed an ethic of care provoked by their concern for staff and patients. Andrew explained: "Sometimes I've had clashes with senior management. For example, they tell you to take in extra clients. So I tell them, sorry, I'm not taking any extra

people because there is so much we can do. I'm not going to compromise quality at the expense of quantity." In fact, Gabriel (2015b) suggested that an ethic of care "highlights the importance of attentiveness, empathy, responsiveness and responsibility for others" (p.317).

Equally, middle managers explained their perceptions of quality healthcare and delivery as focusing on and understanding employees, and creating training opportunities for them. They valued staff members and wanted them to feel that they mattered. Participants' experiences revealed a caring attitude. Besides, participants linked their leadership perceptions to quality healthcare. Participants made the following comments:

Natasha: I want my staff to be happy...I have to ensure that their performance is good. I support and train them. You feel good when everything is going well but then you have to support them as well in troubled times...the focus is the staff...that is leadership.

Abigail: You cannot expect to give a good service to patients if you don't look after your staff....it means respecting them, putting a value on them, training them and understanding what service provision means to them. Leadership must be meaningful."

Participants' leadership perceptions allowed a very clear understanding of the dichotomy in their stories, namely a sense of contentment and fulfilment when there were good patient outcomes, and a sense of disappointment when there was a failure in the system. Participants provided examples of how their organisation provided compassionate care, and also mentioned scenarios where not enough priority to quality care was given. Compassionate care included providing an ethic of care, that is, sensitivity and concern for the needs of patients, supporting and training staff. Additionally, leadership was equated to quality healthcare.

4.3.6 Summary: theme two

Nurse and allied health middle managers frequently found themselves in the thick of things in an environment raising a number of challenges. Whilst there was some variation across the nurse and allied health middle manager groups in the way they expressed organisational challenges, most participants were eager to mention the tiniest milestones achieved and the celebration of them. They saw opportunities and potential in situations, not merely the obstacles and blockages. Networking, support from senior management, peer support and quality healthcare emerged as prominent features of the leadership perceptions of participants. It was clear that these increased their confidence in finding new ways to handle challenging situations. Moreover, participants faced unclear role obligations and expectations within existing bureaucratic lines of authority. This posed challenges leading to the integration of competing and seemingly contradictory demands in their performance and leadership effectiveness.

Emotions emerging out of conflicting and contradictory situations were also evident. Nurse and allied health middle managers fluctuated between helplessness in exercising leadership, and feeling needed and valuable when their contribution was recognised.

4.4 Theme three: leadership training and development

The final theme highlighted nurse and allied health middle managers' perceptions in relation to their preparation for, and support in their middle management role. Whilst all participants agreed that they were barely prepared for their role, their responses varied regarding training outcomes. Recommendations for further training were given. This theme comprises 3 sub-themes: preparation for role, outcome of training and leadership development needs.

4.4.1 Preparation for role

This sub-theme shed light on participants' preparation leading up to their current leadership roles. Nurses' and allied health middle managers' responses were very similar. They emphasised that professional training did not prepare them for their role, simultaneously explaining the painful and challenging process of going beyond the clinical role. Nadine remarked: "You are never prepared for this role. For the first few months it was very difficult. It's difficult to detach yourself from the role of a nursing officer to that of a manager." Anna said: "I didn't come in as a manager. I was trained as a clinician."

All participants described the pride and confidence associated with their clinical knowledge and expertise. Since participants came from the caring professions, they certainly saw a lot of their self-worth in their clinical role. Anthony explained: "None of us was prepared to let go of their clinical role so as to take up the leadership role. Everybody thought that they could do both things at the same time." Nancy recalled the anxiety and insecurity she felt on being appointed to the middle management position: "No, I was definitely not prepared. I had to adjust, and go around and ask. I had to learn a lot. It was a learning experience but it can destroy the person."

Abigail had been in the middle management position for 35 years. She underlined the importance of contextualising her response because at the time she was appointed to the position, the hospital did not have an organisational, corporate or clinical structure: "I think the first 9 years of my career, it was basically battling on my own...I mean it was very, very painful learning phase...you just sort of hoped for the best." However, irrespective of their profession and the number of years they had been in position, all participants gave similar responses, demonstrating that preparation of nurse and allied health professionals for management positions remained limited.

Meanwhile, most participants spoke about the relevance of experiential learning and networking as integral components of leadership training. Middle managers also took up further training under their own steam. Participants shared their thoughts:

Adam: I was not prepared for my role at all...I was trained as a clinician...that's why I sought further courses...It's the experience, sort of, that trains you.

Arthur: We were trained as health professionals...I feel that the experience, the leadership experience that I had before...that helped me a lot. Mostly it's because it not only helps you to network internally with colleagues but I also had a lot of exposure. How do you say this? It's the relationships with other professions.

Amber explained that commitment to learning was equally important: "We never had any structured preparation...it was more the experience that helped rather than anything else. It has to be your own personal initiative. You should strive to seek and make use of learning opportunities." Likewise, Naomi used her previous experience to help her adapt to her role. She communicated honesty and openness, and viewed her mistakes as learning opportunities: "The previous experience in various leadership positions helped...that gave me the confidence to take on this challenge...Having said this, I've had my bad moments and there were times when I made mistakes."

The responses in this sub-theme presented nurse and allied health middle managers' thoughts and emotions on their preparation for their role. All participants experienced minimal training prior to taking up the middle management role. They struggled with role transition from clinical leadership to middle management leadership. This was however compensated by other means such as experiential learning and networking, attributes which facilitated participants' leadership practice.

4.4.2 Outcome of training

In this sub-theme, participants' opinions differed on the outcome of the internal leadership and management training programme. A number of nurse and allied health middle managers described the positive effects of training, and how it gave them a different perspective on how to approach issues. The most valued aspects of training are listed in Table 4.9.

All middle managers agreed that the sharing of leadership experiences during the training programme was of particular benefit, as this supported their needs for collegiality and provided a support safety network for dealing with anxiety-provoking situations. Naomi explained: "The fact that you're participating on a course with various disciplines working in various areas and

you're discussing issues with them; that in itself, it puts things into perspective and you realise that you're not the only one facing certain issues...this fact alone was already a very good thing." Arthur added: "The programme content didn't help me...But the fact that we used to meet and there was a forum element, *that* helped me...you identify with people, with people who'll be reflecting, talking about their own experiences, what they've been through...You get to know them and you know that on the basis of that collegiality, you can approach that person for support and guidance. It's a way of exercising leadership differently. That was very important."

Table 4.9: Most valued aspects of training described by the middle managers.

- | |
|---|
| <ul style="list-style-type: none"> • Source of networking and collegiality • Driver for change and empowerment • Source of guidance, motivation and re-enforcement |
|---|

Beneficial course ingredients mentioned were self-care, communication, delegation, conflict resolution, knowing your team members and "leading from within." Some participants explained that during the training programme, they were taught to move beyond antagonising the system, and to deal with failures within the system. Amanda's meaningful statement revealed this: "The programme motivated me...sometimes during the sessions negativity emerged from certain participants and inevitably almost everybody ended up grumbling. Yet, we were taught to be more positive rather than being helpless. We were told that leadership takes time. They gave us tools...it served as reinforcement and it also acted as a facilitator, as a driver and thirsting to learn more."

Moreover, Alan voiced his inability to empathise with staff members prior to attending the training programme. He subsequently became more understanding and caring. Alan possessed courage to change course, a sign of leadership strength: "The training sessions were very, very helpful. They helped a lot in my attitude with staff because I was quite regimental and you know, sometimes you can't be like that. You have to be understanding."

Middle managers who had been in position for a number of years felt more positive about the training programme than the other participants. They appeared to be able to build on the knowledge gained from training and their experience, and apply both to practice. Abigail said: "I found training extremely stimulating...it's helped to confirm a lot of my ideas, to expand on my ideas."

Conversely, other participants complained that the training programme did not address their needs. Difficulties encountered with training are identified in Table 4.10. Nancy felt that the

training did not help her to deal with the complexity in healthcare: “I think that certain issues and topics that were presented to us, they should have been more in depth...it’s true that things are complex...neither black nor white but I felt that some issues remained grey to me.”

Table 4.10: Difficulties encountered with training as identified by participants.

- | |
|---|
| <ul style="list-style-type: none">• Addressing workplace complexity• Translating training into practice• Enabling participants’ optimal performance |
|---|

Moreover, most nurse and allied health middle managers insisted that they experienced difficulties in translating training into actual practice. Participants also reflected on the demands and constraints imposed by the healthcare context. This is how they shared their experiences:

Nicole: I feel that some of the lecturers did not appear to be in touch with the difficulties within the health sector. They tell you, this is the way things should be done. Of course, we know that but in practice it does not work.

Adam: In terms of course content, it was excellent, it was good, but when it comes to practice, you’re totally restricted...you cannot put the theory into tangible practice...we don’t have control over certain issues. We’re not involved. Our contribution is not recognised...What sense does it make that you give me the knowledge and I can’t apply it in practice? It’s very frustrating.

In addition, participants observed that leadership did not happen automatically through training. It developed with time, and although leadership skills could be learnt, individuals needed patience, and had to work hard, consciously and continuously to develop their leadership potential and deal with complex situations. Nadine reflected: “Training can never prepare you for the truth. They [trainers] make you aware of situations and they may help you in this respect but when you’re in a tricky situation, you have to make use of your wisdom, experience and common sense...knowledge in leadership will always help but it will *not* make you a leader.” Abigail added: “Nobody teaches you how to lead...what people do teach you is very prescriptive, about teambuilding, about communication...nobody teaches you leadership. You find that out for yourself.”

For this sub-theme, participants held different views regarding the leadership and management training that was offered by their employer. While there was general consensus that networking helped them deal with everyday work realities, participants reported that training had helped them individually to different extents. However, when probed further, most participants

explained that in general, the leadership and management programme did not significantly contribute towards enabling their optimal performance. In particular, training did not prepare middle managers for workplace complexity, and the stressful situations they experienced. This created frustrations.

4.4.3 Leadership development needs

This sub-theme captured the views of participants regarding practices to facilitate and support their leadership development. The need for mentoring programmes, and communities of practice professional development approaches were positively supported by most nurse and allied health middle managers. This is how participants identified how mentoring could develop their leadership practice:

Nicole: I suggest that we're mentored on the job. It would be excellent if you'd have someone going around with you. It's as if you'd have someone in your pocket...it's not someone who tells you what to do but someone who guides you to find the right solutions.

Adrian: If the training had been followed up with mentoring at my workplace, yes I think that would have helped me to improve...I wouldn't have expected that they give me a solution but they would have made me more aware of my weaknesses and how I can work on them.

The majority of nurse and allied health middle managers also spoke about the need to have regular interaction with colleagues and to tap into other people's experiences. Participants explained that using networking for training purposes would help them to think differently and refine what they were doing. Hence, they would not be left to deal with the complexity of the healthcare system on their own. Communities of practice would provide a support safety network, supporting participants' needs for collegiality, which also served as a self-preservation strategy. Middle managers spoke about the beauty of acknowledging and involving peers, ensuring that many health leaders moved in one direction and shared in the success of healthcare delivery. Networking or communities of practice have been described as a group of workers sharing a common interest in a particular area. Communities of practice may also be created specifically for gaining knowledge related to a specific field (Kothari et al. 2011). It is through this process of sharing tacit information, experiences and interactions that nurse and allied health middle managers learnt from each other, and had an opportunity to develop themselves personally and professionally. These excerpts are examples of participants' thoughts and insights:

Aaron: I believe that as leaders we need to communicate more with each other and share experiences. Or else, have case scenarios with real experiences we've encountered...if you had this difficulty at your workplace, how would you deal with it? And the different leaders would share what they would have done. So next time I encounter something similar, I know what I can do...I really relish other people past experiences and I believe that they may help me to move forward.

Arthur: It's this idea of communities of practice...it means acknowledging the expertise but you also learn to involve others...that means that you have a team of people moving forward.

In this sub-theme, nurse and allied health middle managers focused on their leadership development needs. The participants agreed that mentoring programmes and leadership development approaches using communities of practice would greatly benefit middle managers in their healthcare positions.

4.4.5 Summary: theme three

Participants agreed that they had minimal training before entering their middle management roles, and that much of the skill essential for effective leadership was learnt through experience, rather than training. Middle managers identified opportunities that exposed them to alternative leadership development activities within the organisation. Most participants felt that mentoring would support their leadership development with an opportunity to seek advice. Participants also saw leadership development opportunities through collaboration and networking. The study revealed that networking was also one of the most consistently positive leadership perceptions and training outcomes. It enhanced communication and collaboration, and in turn improved intraorganisational relationships. In summary, communities of practice professional development approaches and mentoring programmes were seen as possible development strategies for empowering and supporting nurse and allied health middle managers to deal with the complexities, contradictions and ambiguous situations of the acute healthcare setting.

4.5 Divergent views

One allied health middle manager stood out in having general negative views about his leadership perceptions and leadership training and development. Unlike the other participants, Abraham described a very traditional view of leadership. He presented himself as all-powerful, directive and all-knowing, almost like dictating what needs to be done: "I have seniority and automatically I have to take up certain responsibilities. It's traditional sort of...you'd recognise a leader through his actions. Normally you'd see him giving orders; you'd see him writing behind a desk." Abraham also voiced vague and contradictory notions of leadership: "I don't

like taking the lead role but if I'm given the lead role, I will act. If it's forced upon me, yes I will act and I will do my best."

Revealing quotes of embitterment persisted throughout the interview. For example, when asked to identify leadership qualities, his terse reply was that "you'd find these in the literature." Yet, when Abraham was probed further, he said that he experienced leadership as the integration of positive opposites: "Sometimes, it may be that you'd have to sacrifice control at the expense of flexibility" using "experience and judgement." He disclosed that he had been denied promotions during his career. Thus, he felt antagonised towards the organisation: "I've had a lot of obstacles in my own promotions to senior positions...I feel this is unfair...these are the fault cracks within the organisation...there's nothing you can do." He felt "destroyed."

Moreover, Abraham narrated a situation where he conducted a cost control exercise within his department: "I already did this exercise before but nobody took any notice of it. Now it's been done again and we're seeing the results...I feel I have made an impact." Despite displaying bitterness and cynicism, Abraham appeared to relish the respect of others, and sought distinction and achievement for results. He yearned to be supported in his work activities. This corroborated the views of the other middle managers.

He also felt that most of the things learnt during the leadership and management training programme remained "a lip service." Similar to other participants, he affirmed that he was "unable to put into tangible practice" what he learnt. Abraham explained that during the programme, healthcare managers were encouraged to take initiatives: "*Go ahead and do it. Do not be afraid. You'll have the support but then you realise that the support does not exist...then I refused to attend the follow-up lectures.*" Abraham revealed another confirmation of bitterness and authoritarianism when he added: "I've learnt enough now. I have 12 years of practice as a manager in the private sector, in the hotels industry. When I applied for the managerial post, this wasn't even taken into consideration." Abraham possibly felt alienated from the organisation and found the private sector more promising and fulfilling.

In summary, Abraham's outlier comments set him apart from the other participants. He presented a slightly different picture of his leadership experience and expressed it differently. He certainly felt negative in relation to possibilities. Conversely, most nurse and allied health middle managers were generally more confident about concerns being dealt with, particularly amongst peers.

4.6 Conclusion

This chapter has reported the analysis and findings of nurse and allied health middle managers' interviews. As a conclusion drawn from the description, explanation and ongoing analysis of the 3 key themes and 12 sub-themes, 4 major findings were derived. This was done in the context of the key concepts constructing the theoretical model used in the research study. Figure 4.2 shows a visual representation of the major findings. The process of analysis and interpretation from the interview transcripts through to the final findings was explained, and comprehensively and critically discussed in Chapter 3. Appendices XI to XVII illustrate this process. The findings were:

1. Nurse and allied health middle managers experienced a range of intense emotions in their roles.
2. Middle managers experienced organisational challenges and struggled to achieve a balance across conflicting and contradictory situations.
3. Training did not significantly contribute towards enabling optimal performance of middle managers.
4. Middle managers would benefit from communities of practice professional development approaches and mentoring programmes.

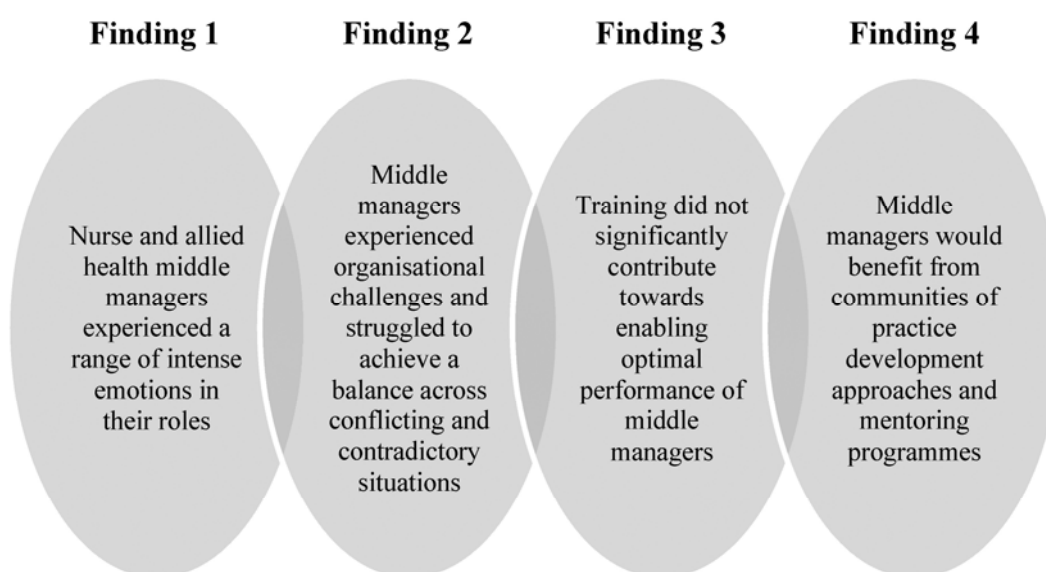


Figure 4.2: Visual representation of study findings. Findings were drawn from the description, explanation and ongoing analysis of the 3 key themes and 12 sub-themes.

The 4 findings generated are discussed in the next chapter. The significance and interpretation of these findings are described with reference to the literature reviewed and the research questions, whilst remaining faithful to the perspectives of the study participants.

Chapter 5 Discussion of findings, recommendations and conclusions

5.1 Introduction

In chapter 4, I presented the findings and proposed an explanatory account of the leadership experience of nurse and allied health middle managers working within an acute healthcare setting. In this final chapter, I discuss these findings in terms of how they answer the research questions. The 3 themes and 12 sub-themes provided rich descriptions of the 21 nurse and allied health middle managers' leadership perceptions. Four major findings were identified from these themes and sub-themes that best described the leadership experience of the study participants. These were:

1. Nurse and allied health middle managers experienced a range of intense emotions in their roles.
2. Middle managers experienced organisational challenges and struggled to achieve a balance across conflicting and contradictory situations.
3. Training did not significantly contribute towards enabling optimal performance of middle managers.
4. Middle managers would benefit from communities of practice professional development approaches and mentoring programmes.

In the next sections, findings are discussed and supported in relation to addressing the research questions, and to the existing literature on the leadership experience of healthcare middle managers considered in Chapter 2. In conclusion, I summarise the thesis, restate the significance of the research and identify the limitations of the study. The main conclusions, with implications for practice and future research are also made. Recommendations are presented based on the interpretation of these findings.

5.2 Interpretation of findings

The qualitative methodology provided a deep understanding of the subjective leadership experience of nurse and allied health middle managers working within the acute healthcare setting of MDH. The focus of the methodology was the exploration of the meanings attached to actions, experiences and perceptions of the study participants. The data emerging from the interviews provided a meaningful understanding of middle managers' leadership perceptions (Squire *et al.* 2013). Moreover, participants appeared to use their own narratives and storytelling as sensemaking tools (Gabriel 2004a; Boje 1991), through which they constructed and reconstructed meaning for their own understanding, and through which they sought to "interpret and create sense for themselves and others of their changing organizational context

and surroundings” (Rouleau and Balogun 2011, p.955) Hence, in this study, sensemaking permitted nurse and allied health middle managers to organise, interpret and reflect on their leadership perceptions, stimulating their personal growth and development.

Moreover, participants shared reflective accounts of their leadership perceptions, which created meaning of their reality, and made sense of what happened, or what they imagined to have happened (Currie and Brown 2003; Taylor 2003). This account of reality helped to uncover knowledge regarding characteristics that influenced middle managers’ leadership experience and activities. In addition, clarifying the personal challenges, concerns and motivations of the leadership experience of participants, offered insights to the leadership development and training that may enhance the competencies of middle managers and support them in their roles. I now discuss the significance and interpretation of the 4 major study findings.

5.3 Leadership perceptions

Within the context of this study, participants’ leadership perceptions were characterised and shaped by intense emotions, underscoring the various competing demands and expectations encountered by middle managers in acute healthcare settings, as signified by the CVF. Nurse and allied health middle managers spoke about their perceptions, their journeys as leaders, mentioning the little triumphs and also, the setbacks along the way. Indeed, the emotional dimensions of leadership emerged to the forefront of the study as middle managers’ perceptions were portrayed through the interview accounts. Participants’ accounts of their perceptions were very helpful in that they drew participants out of their comfort zones and opened valuable windows into their experiences as members of an acute healthcare organisation. Accounts of individuals’ experiences are particularly relevant in healthcare settings for the unfolding of emotions (Lökman et al. 2011). Some interview questions appeared to evoke an even stronger emotional response. Participants were frank and able to articulate and illustrate their leadership perceptions along with their emotional dimensions. They demonstrated the importance of emotions in their organisational life and revealed the intense and diverse emotions they experienced: pride, contempt, care, indifference, disapproval, hope, disappointment, anger, excitement, anxiety, joy. This is in contrast to what has been reported in the literature, where emotions are not duly acknowledged in organisational texts (Fineman 1993). Generally, organisations have a pejorative view of emotions (Ashforth and Humphrey 1995). This is because it is assumed that emotionality is in direct opposition to rationality.

However, since the 1990’s a lot has been written on emotion in organisations. More recently, Hochschild (2003, p.17) claimed that emotion communicates information and subsequently, individuals discover their “own viewpoint of the world.” This is consistent with the findings of this study. Nurse and allied health middle managers demonstrated that “[f]ar from being

emotional deserts, organizations are full of emotion and passion” (Gabriel and Griffiths 2002, p.214). Besides, leadership has been described as managing “on the edge of chaos” (Marion and Uhl-Bien (2001, p.410). Hence, it is not surprising that managing expectations within MDH and facing a multitude of changes was a major challenge for study participants, in which they felt and displayed emotions (McColl-Kennedy and Anderson 2002).

Hochschild (2003, p.34) highlighted how very often the “real self” of individuals remained hidden as a form of protection against the organisation. However, nurse and allied health middle managers in the study appeared to use the interview to release their inner self, making it accessible to themselves and to the researcher. The research study therefore provided an opportunity for participants for emotional expressiveness and self-reflective enquiry, using it to improve the rationality of their leadership practice. In their accounts, middle managers exercised independence of the organisational influence, and were able to reflect critically on the situations they faced, as well as on the attitudes and behaviours they brought to those situations (Jin and Rounds 2012). This self-reflective process “can expose mystification and enable demystification to occur” (Höpfl and Linstead 1993, p.77). When emotions are surfaced and questioned, a space is created for alternatives to be considered, and movement from one fixed way of seeing the world to another becomes possible. Presumably, this happened in this research study whereby middle managers engaged in a process of sensemaking in an attempt to build and refine their leadership experience, simultaneously revealing their emotions. Emotional expressiveness appeared to be necessary for them to be able to better understand their leadership role within their organisation, and the conflicting demands across the ambiguous situations they encountered. Responding to organisational expectations through their emotions, reflected the contradictory criteria of leadership effectiveness reflected by the CVF (Viitanen and Konu 2009).

In his published work on sensemaking in organisations, Weick (1993) explained that sensemaking “emerges from efforts to create order and make retrospective sense of what occurs” whilst individuals “try to make things rationally accountable to themselves and others” (p.635). Maitlis (2005) added that sensemaking “helps people to deal with uncertainty and ambiguity” (p.21). Therefore, when individuals are able to make sense of an ambiguous situation, they will then be able to provide a new reality for others. Gioia and Chittipeddi (1991, p.443) described this process as the sequential and reciprocal cycle of sensemaking and sensegiving, where individuals attempt to influence others’ understanding of an issue. This description mirrored the process witnessed in the research study, whereby nurse and allied health middle managers sought to make and give sense to their perceptions in response to the interview questions, revealing the emotional impact of leadership.

Nurse and allied health middle managers disclosed the varied challenges and role demands and expectations highlighted by the CVF (Lawrence et al. 2009). This provoked emotional reactions that were sometimes overwhelming. This is not surprising given that in the context of complex acute health settings, affective elements are particularly significant (Ball 2014). The importance of emotions emanating from middle managers' leadership challenges has been recognised in other interview studies with middle managers in healthcare organisations (Buchanan et al. 2013), and in public and private sector organisations (Denham et al. 1997). This study confirmed how nurse and allied health middle managers' contradictory position was likely to lead to emotions such as stress and worry. Participants gave strong and meaningful statements, many times suggesting that a supportive environment buffered these stressful situations, and gave them strength and motivation to tackle complex issues. Nurse and allied health middle managers reported that positive emotions motivated them to work more effectively and efficiently, and also raised optimism and enthusiasm amongst their employees (McColl-Kennedy and Anderson 2002). Conversely, when there was lack of support, appreciation and meaningful guidance from senior management, study participants experienced various levels of frustration, and loss of confidence in their abilities and positions as middle managers. This lack of support and protection from superiors was likewise identified by Kokkinen et al. (2007) in their study with middle-line managers in a hospital in Finland. Indeed, emotions experienced by middle managers were dependent on their relationships with senior management and peers, as well as the organisational climate in general.

The paradox of participants' display of emotions was evident in this study. Nurse and allied health middle managers appeared to be torn between positively influencing staff and protecting their own position, not wanting their emotions to be mistaken for resistance and thus, to be perceived by their employees to be lacking leadership qualities. They may have feared that their own insecurity and uncertainty would adversely affect motivations and emotional states of their staff, as well as staff members' perceptions of their own "effectiveness and credibility" (Lewis 2000, p.223). There are similarities between this finding and that described by van der Kam et al. (2014). Drawing on the work of other researchers (Palanski et al. 2011; Palanski and Yammarino 2007; Simons 2002), these scholars raised awareness that subordinates are likely to question their leaders' decisions when they perceive their leaders to portray disappointing behaviours. Sims (2003, p.1208) contended that "most juniors cannot tolerate the ambiguity that would result if they believed that their middle managers might not genuinely be able to follow the plot."

Moreover, middle managers appeared to display emotions that they perceived were required of them, even if this came at a cost (Hochschild 2003). This is what is called "emotional labour"

and it occurs “through the necessity to remain in control and to deny the presence of stress and ambiguity” (Putnam and Mumby 1993, p.49). On emotional work, Craib (1998, p.113) said:

Individuals, people – men and women – are by definition engaged in at least two interlocking forms of emotional work: the ‘internal’ work of coping with contradiction, conflict and ambivalence and the ‘external work’ of reconciling what goes on inside with what one is ‘supposed’ or ‘allowed’ to feel.

Indeed, Menzies’s (1960) classic work of how hospital staff deals with anxieties cannot be disregarded in the context of this research study. “Nurses, argued Menzies, operate in an emotional maelstrom of demands and expectations made by patients and their relatives. These include both positive and negative emotions, ‘rational’ and ‘irrational’ ones, ranging from gratitude, respect and admiration to envy, resentment, contempt and rage” (Gabriel 2015a, p.618). The emotions described are defensive routines that take the form of many different behaviours and thinking patterns, protecting health workers from the anxiety associated with their work. Menzies’s contribution is very relevant to the leadership experience of healthcare middle managers in this study. This is because defensive techniques aimed to contain middle managers’ anxieties, ended up reinforcing these anxieties instead. It appears that “social defenses” against anxiety described by Menzies more than 50 years ago are still prevalent and unchanged (Bain 1998, p.413). The reason for this is that health systems continue to arouse the “same unconscious and deeply ingrained defences”, and as healthcare managers become engrossed by their staff needs, they do not focus on their own emotional needs (Fotaki 2010, p.708).

Nevertheless, although hospital work contains a constant sense of stress, middle managers still found ways of coping, managing both their positive and negative emotions. Despite their sometimes pessimistic tone, the majority of participants survived the negative emotions, and generally expressed a positive attitude. They did not show a loss of commitment towards their role and worked hard despite the insecurity they sometimes felt. Performing challenging tasks appeared to give them a sense of achievement. This may be partly explained by middle managers’ main motivating factors coming from positive emotions, support by senior management and networking. Certainly, the positive emotions expressed by nurse and allied health middle managers may have had inspirational and motivational consequences (Lewis 2000). Participants’ own emotional stamina thus helped them to withstand the many frustrations they experienced, “blanking out the larger threatening context and focusing on the smaller, more isolated and controllable portions of their jobs” (Huy 2002, p.44). On a similar note, Gabriel and Griffiths (2002) stressed that a factor that may have a considerable effect on the containment of negative emotions is the ability to mobilise positive emotions of “hope, courage, self-reliance and dedication” avoiding “total exposure to every adversity” (p.219). The ability to contain

negative emotions leads to positive effects like “innovation, change and learning” (p.220). Furthermore, middle managers’ interactions with their staff and the encouragement of a participative culture helped them to work through others. Such interactions provided a highly stimulating work environment for themselves and others. Thus, emotions helped in supporting organisational activities (Gabriel 2010).

In general, middle managers expressed a sense of pride and optimism. The factors that participants claimed to promote leadership practice promoted feelings of self-worth, autonomy, control and professionalism, which are all emotion-laden. Such actualising tendencies appeared to serve as driving forces towards participants’ self-preservation, self-care and well-being. Consistent with this argument, feelings of professional pride in patient service delivery were reported to make up for participants’ desire for unrecognised contribution in their middle management roles. Healthcare middle managers come from the caring professions, and are therefore “familiar with the art of caring” (Carlström 2012, p.92). When nurse and allied health middle managers were asked to illustrate good quality healthcare and leadership, they focused consistently on patient care. They also gave examples of quality care, showing genuine concern for patients (Gabriel 2015b). In fact, throughout their interview accounts, participants strongly suggested that exercising leadership included caring for others (Ciulla 2009). Caring and compassion were central to middle managers’ emotions. These were mainly defined through attentiveness, empathy, sensitivity, responsiveness and responsibility. Nurse and allied health middle managers cared for their staff and offered recognition and support. Caring meant giving them time, listening, affirming, understanding and encouraging. The findings from this study also suggest that participants acted as “toxic handlers” for employees protecting them from excess stress and anxieties (Frost and Robinson 1999, p.98). The study therefore highlights the healthcare manager as the person in the middle “continually engaged in a balancing act, and buffering and sheltering those below from consequences of mistakes” (DiPadova and Faerman 1993, p.147). Yet, they still maintained their ability to exercise discipline, challenge and evaluate when necessary, offering constructive feedback, and helping staff discover their own worth. This is revealing as the literature has given very little attention to leadership and care, even though leaders are always judged by their followers “against their ability *to demonstrate that they care*” (Gabriel 2015b, p.317). The emotion of caring certainly made the leadership experience of participants in this study different and unique. It seems imperative therefore that the value of care in leadership needs to be further explored.

Fineman (1993, p.19) raised awareness of the risk of “expulsion from the professional community for revealing ‘inappropriate emotions’.” This did not appear to be the case with the nurse and allied health middle managers participating in the study as they did not sanction their emotions (Hochschild 2003). Undoubtedly, participants disclosed much data about their own

emotions. They had no hesitation to delve into the emotional aspects of leadership, promoting a humanised environment and implicitly acknowledging that emotional expression helped them to deal with the complexity and competing demands of healthcare, as underlined by the CVF (Melo et al. 2014). Quinn (1988) argued that organisations carry within them various models of managerial leadership, which are often contradictory, thereby creating potentially conflicting expectations for the middle managers. Nurse and allied health middle managers demonstrated a need to be sufficiently resilient to cope with the emotional stress and strain arising out of such situations. This finding provides a further contribution to emotions in healthcare literature. The emotional dimensions of leadership indicate that emotions deserve greater attention in understanding effective leadership of nurse and allied health middle managers.

5.4 Seeking a balance

This study revealed that uncertainty and paradox are inherent within healthcare systems. This is widely reported in the literature (Linton and Farrell 2009; Mickan and Boyce 2007; Downey-Ennis and Harrington 2002; Hackett and Spurgeon 1998). Challenges impacting on middle managers' abilities to lead within their organisation were revealed through the paradox existent within the workplace setting and through participants' middle management role. Nurse and allied health middle managers' roles required them to be in the thick of complex organisational structures, facing daunting challenges, multiple demanding relationships, and rapid change (Yukl 2010, p.86; Downey-Ennis and Harrington 2002; Uytterhoeven 1989). Accounts of role conflicts and dilemmas emerged repeatedly in the data. Additionally, staff members expected participants to have all the answers, being powerful, directive and all knowing. Participants described their experience of being the leader in the middle who was required to interpret, communicate and implement decisions made at a higher level, and simultaneously get subordinates on board to execute them. Consequently, they were expected to accommodate diverse demands, and to be collaborative rather than controlling. Participants voiced that they were in constant search of balance between flexibility and maintaining control; being directive and being empowering; being a boss and being a friend. This finding recognised the integration of competing expectations related to the competing functions of healthcare middle managers' position as highlighted by the CVF (Lawrence et al. 2009). It also echoed the view of Yukl (2010, p.259):

The "leader in the middle" is expected to represent the interests of superiors to subordinates, and to represent the interests of subordinates to superiors. He or she is expected to implement decisions made at a higher level of authority, but also to challenge weak decisions. Leaders are expected to initiate and guide change, but they are also expected to encourage and support "bottom-up" changes suggested by followers. A leader is held responsible for everything that happens in his or her team or

work unit, but encouraged to empower followers to act on their own in resolving problems.

Middle managers maintained that their roles were accompanied by tension caused by “multiple and often competing demands, and concerns” (Berg and Huot 2007, p.1774). When participants experienced role conflict and ambiguity, and contradictory and unclear expectations, they expressed severe disappointment and alienation because they were unable to meet simultaneous expectations. The competing and contradictory demands on middle managers and unclear role obligations have been reported consistently in the literature (Currie and Procter 2005; Denham et al. 1997).

Besides, the balancing and the integration of emotions emerging out of conflicting and contradictory situations were very much evident in the data. Participants spoke about the tensions experienced in managing their own as well as employees’ emotions. Their descriptions of their middle level position supported for example the work of McConville and Holden (1999). These researchers wrote about middle managers’ experience of being caught in the middle, owing loyalty to senior management, their employees, the patients and the exigencies of the service. These scholars similarly revealed that healthcare middle managers “are fulfilling a vital role in balancing tensions and mediating potential conflict, often at personal, emotional cost” (p.422). The interpretation of the data in the present study clearly suggests that balancing of emotions prevailed widely and it occurred within a complex interplay of multiple dynamics of relational perspectives involving the middle managers, senior management, peers and subordinates as "elaborate relational networks" within the healthcare context (Uhl-Bien 2006, p.661). The study underlined the value of emotional balancing for nurse and allied health middle managers working in an acute setting to support both their practice and their values. The study finding also corroborated earlier work by Huy (2002) and Fineman (1993) when they talked about the emotional balancing used by middle managers to balance their own as well as their employees’ emotions in order to maintain operational continuity and achieve the desired outcomes. Certainly, study participants found the integration of leader and follower roles to be a challenging venture. Moreover, they struggled to conform to expectations of higher management and their own staff, indicating that traditional leadership theorists may have underestimated the complexity of the emotional relationship between leaders and their followers (Denison et al. 1995). This finding revealed the positioning of the participants in terms of the CVF and the complex and paradoxical demands of leader and follower roles (Yang and Shao 1996).

In general, nurse and allied health middle managers participating in the study are believed to have been balancing out the roles that were expected of them through the unconscious observance of rules set by senior management and their own staff. Very often, they saw

themselves to be embedded in networks that they did not fully control. This finding was highlighted in Goffman's seminal work. In 'The presentation of self in everyday life', Goffman (1959, p.8) elaborated how individuals under normal work circumstances project and present their activities as "performances" established specifically through social interaction processes. As a result individual behaviour is determined and derived out of the social interaction with others, as well as from the interpretive activity of the audience. In other words, the behaviour of research participants may have been constructed according to the expectations of those involved in the interaction.

Besides role confusion, middle managers also spoke about ambiguous situations, revealing that sometimes they felt overwhelmed by this challenge. They mainly attributed these organisational uncertainties to their lack of control and decision-making. There were times when they felt that their professional opinion did not matter. They yearned to be empowered to share their opinions, and felt apprehensive and insecure because of the lack of recognition. This finding also emerged in Dopson and Stewart's (1990) study. These researchers reported that middle managers complained about having to cope with additional pressures, and not being consulted before unexpected changes. In addition, nurse and allied health middle managers experienced uncertainty avoidance, claiming to miss their old roles. They further explained that their involvement in decision-making was conducive to their engagement, empowerment and quality healthcare (Wong et al. 2010). Hence, participants continually sought balance and compromise, balancing tensions in their everyday work practices. Subsequently, they allotted considerable energy to negotiate their way to make things work, focusing on patient needs, whilst leading, supporting and developing staff, and treating them with consideration and respect. They described their influence on staff, and often expressed concealing their thoughts in order to positively influence staff and patient care. This finding resonates with Knies and Leisink's (2009) research with healthcare middle managers in the Netherlands. These researchers concluded that despite organisational constraints, healthcare middle managers offered support to their employees, stimulating their commitment and career development.

Overall, nurse and allied health middle managers felt apart from higher management. It is likely that one reason for this was because participants worked their way up within their organisation, and consequently felt closer to clinical staff. This is similar to what Carlström (2012) reported in his study with healthcare middle managers in Sweden. He observed that although middle managers represent senior management, they also "align themselves with staff and patients, taking on advocacy roles in a position that is displaced downwards" (p.92). This finding continued to reaffirm healthcare middle managers' paradoxical position.

The general positive attitude expressed by most nurse and allied health middle managers despite organisational challenges and role conflicts, can be partly explained through the satisfaction gained with getting things done through staff. Participants described situations where they managed relationships and influenced staff members toward common goals by fostering teamwork, developing trust and managing conflict. Middle managers struggled to positively influence staff. This may have occurred because fear, insecurity and uncertainty may have been interpreted as inappropriate leadership behaviours by middle managers, and they did not want to appear as if they were resisting the higher management. This further demonstrated the paradox within their leadership role, in that they struggled between demonstrating confidence to positively influence staff and protecting their position, possibly not to be seen as resisting higher management and lacking leadership abilities. They balanced responsibilities and integrated contradictory factors, thus fulfilling paradoxical expectations. This finding is likewise reported in the CVF literature. The CVF underlines the tensions, contradictions and paradoxes that characterise leadership (Lavine 2014). It also suggests that for leaders to be effective, and to meet the competing demands and tensions of the organisation, they have to perform contradictory roles and fulfil competing expectations (Lawrence et al. 2009; Yang and Shao 1996). Indeed, the contrasting aspects contended by the CVF are so true because nurse and allied health middle managers in this study all talked about experiencing them.

Certainly, without support from their seniors, and networking with their peers, nurse and allied health middle managers were unable to cope with, and take on the demands of the complexities of the acute healthcare setting. Peer support helped them in employing resilience leading to their self-preservation and possible survivorship. This is consistent with McConville and Holden's (1999) study. These scholars found that without consistent support from seniors, middle managers in 2 acute services hospitals were unable to take on the demands of their role conflict and ambiguity, and the continual change within their organisation. This finding also lends support to the earlier notion indicated by Rousseau (1995) regarding cooperation amongst colleagues. She claimed that cooperation amongst colleagues is a central issue shaping the interactions of employees in order to support each other. When this happens, co-workers are said to "share the same psychological contract" (Rousseau 1995, p.46).

The provision of quality healthcare may have been another factor that motivated middle managers to behave in ways beneficial to the organisation. It appears that healthcare middle managers facilitated quality healthcare through genuine and positive relations with staff (Wong et al. 2010). Clearly, middle managers achieved satisfaction from their ability to influence service provision. They energised their staff to influence service provision, and in turn they were energised themselves, creating a natural cycle of motivation. Additionally, when

difficulties arose, overall, they were able to rise above these and instead, associated themselves with success at the workplace.

The research shows evidence that healthcare middle managers played a tightrope game. They continually sought balance in what they were doing and saying, demonstrating the contradictory demands of leadership. This posed challenges and uncertainties leading to the integration of competing and seemingly contradictory demands in their performance and effectiveness in terms of the CVF theoretical model (Yang and Shao 1996; Denison et al. 1995). Shifting focus in order to attain a balance “does not mean that...[nurse and allied health middle managers] are momentarily possessed of a certain mixture of physiological states or expressions. It means, instead, that from moment to moment...[they] are focusing on different features of the situation” Hochschild (2003, p.234). Research findings are in line with other research carried out with middle managers. Berg and Huot (2007, p.1774) asserted that middle management roles are accompanied by “multiple and often competing demands, and concerns.” Nurse and allied health middle managers functioned within a context of complex, conflicting and contradictory expectations (Viitanen and Konu 2009; Sims 2003), and attempted to create leadership value through the integration of positive opposites (Cameron et al. 2006).

5.5 Preparation for role, training outcomes and development needs

Nurse and allied health middle managers reported very mixed perceptions of the leadership and management training programme provided by their employer. These ranged from increased skills and confidence, to ineffective outcomes. Most participants highlighted the difficulties in applying training to practice; others revealed that generally, training did not help them to deal with healthcare complexity. It must be emphasised however that this finding did not suggest that training did not lead to improvement in knowledge outcomes.

There was however general consensus amongst participants that leadership and learning were indispensable to each other. Effective leadership was based on continual growth and self-development. This is consistent with Snell and Dickson’s (2011) research with individuals employed in healthcare organisations, some time after they had participated in leadership development programmes. Moreover, all middle managers reported that they had minimal preparation for their middle management roles. This finding suggests that when nurse and allied health professionals were promoted to their middle management positions, their professional training did not prepare them for the significant challenges and paradoxical situations, inherent in their role and in the workplace. They pointed out that “leadership development is not a luxury but a strategic necessity” for them (Downey-Ennis and Harrington 2002, p.69). There are therefore implications for healthcare organisations at both practice and research levels to ensure

that what helps and does not help middle managers in their roles is recognised and appropriate training is provided. These implications are discussed in sections 5.8 and 5.9.

Eventual leadership and management training organised by MFH helped participants individually to different extents. Despite the investment in training, the study did not show evidence that training resulted in more effective leadership for most nurse and allied health middle managers. This finding was unexpected and suggests a misalignment between training and leadership practice. The leadership and management training programme was initiated because MFH was concerned about the leadership and management competencies of its healthcare managers. Besides, MFH was committed to the education and developmental needs of its leaders (Micallef 2011). When an organisation invests in leadership development programmes, the implicit assumption is that training investment produces considerable results (Snell and Dickson 2011). In fact, findings from a study with healthcare managers conducted by Bergman et al. (2009) in a major hospital in Sweden indicated that leadership training courses strengthened and supported managers in their roles. Conversely, nurse and allied health middle managers in this research study had very mixed feelings about the managerial leadership development programme. Nonetheless, the study finding is consistent with reports in the literature, where it is apparent that findings about the effectiveness of leadership and development vary (Parry and Sinha 2005; Day 2000; House and Aditya 1997; Burke and Day 1986). A possible explanation may be that for the programme to be effective, it has to be ensured that the right development is offered to the right leaders at the right time (Collins and Holton 2004).

Middle managers asserted that effective leadership was largely learnt through experience. Their daily interactions within their organisation were an invaluable resource for their learning (Denis et al. 2010). Notwithstanding their experience, active self-directed learning and training, when faced with complex situations, most middle managers felt ill-prepared. Though they did have previous leadership roles and held interacting relationships with various professionals, nurse and allied health middle managers were now unable to play the same part in their middle management role. The Greek philosopher, Heraclitus had come up with the classic statement for which he is so famous. He had stated that it is not possible for a man to step twice in the same river as it is not the same river and he is not the same man (Harris 1994). This statement depicts the state of motion of individuals, and the various conflicting and contradictory situations encountered in the work environment. Views expressed by participants were congruent with Heraclitus's statement, in that the leadership role played by middle managers in previous and present roles changed, evolved and developed. Hence, effective leadership required flexibility as the situations around participants evolved and changed. Moreover, middle managers have to be always developing and learning.

Clearly, several middle managers reported the difficulties experienced in translating training into actual practice. House and Aditya (1997) likewise suggested that there is a need to develop methods to transfer theory into practice application, so that managers are able to make effective use of what they learn in their training. Day (2000) added that “[e]ffective leadership development is less about which specific practices are endorsed than about consistent and intentional implementation” (p.606). Moreover, since nurse and allied health middle managers struggled to cope with their role confusion, and with the paradox and complexity of the healthcare setting, they felt vulnerable and insecure about their performance. Inability to make effective use of training during practice caused further emotional pressure. Nabitz and Walburg (2000) described how in the absence of training adequately addressing workers’ needs, they are inclined to either engage in positive thoughts or disengage and alienate themselves from the service. The latter situation did not appear to happen with most of the study participants.

Notwithstanding these findings, all nurse and allied health middle managers described the relationships formed in the course of their participation in the leadership and management training programme, and the sharing of leadership experiences as meaningful, and having an important impact on their leadership. Participants described how the interaction with other healthcare middle managers functioned as a form of support within their organisation. Subsequently, they put a great value on interactions with peers, seeking mutual trust, support and advice through a network of people, which then allowed them to challenge each other. The significance of supportive relationships and peer networking leadership development has been widely reported in the literature (Edmondstone 2011; Miller et al. 2007; Woltring et al. 2003). For example, in his research with 25 Swedish middle managers in hospitals and primary care, Carlström (2012) noted that such interactions were formalised “to encourage middle managers to continue their role in the middle and avoid sliding out” (p.102). Indeed, these communities of practice provided middle managers with a sense of value and recognition (Edmondstone 2011; Brown and Duguid 1991). They explained how they felt the need to tap into the shared knowledge and leadership of their peers for more effective solutions in ambiguous and complex situations. Participants’ interactions during the training programme certainly supported them in professional service delivery. This is in line with Morgan’s (1989) assertion. He attested that “[m]anagers face a tidal wave of situations, events, pressures, and uncertainties, and they naturally resort to collective discussion (in the broadest sense) to negotiate an acceptable set of relationships that provides satisfactory explanations of their social worlds” (pp.94-95).

Consequently, nurse and allied health middle managers sought to learn through challenging their own assumptions, seeking perspectives from the experiences of other health professionals, reflecting on past situations and evaluating alternatives. This is echoed by West and Lyubovnikova (2013) who proposed that reflexivity is crucial for healthcare teams as they can

ponder upon what they need to change and then make the necessary adjustments. Similarly, the results of the research conducted by van der Vegt and Bunderson (2005) with teams composed of scientists, engineers and technicians, clearly suggested that team learning through interaction affects performance outcomes. They recommended that “under the right conditions, expertise diversity can be a key activator of intrateam learning and thereby promote overall team effectiveness” (p.543). The findings from the present research supported this claim. Furthermore, middle managers showed an ability to use a different learning process through discovery of new knowledge. This generated personal meaning from their own leadership experiences relevant to their needs and goals (Kolb et al. 1984).

It is noteworthy that participants who had been in their position for a number of years were more optimistic about the outcome of training. This may be because critical self-awareness of their leadership experience provided these middle managers with an understanding of their capacity to change practice. Therefore, years of experience provided the foundation on which they developed further leadership knowledge and skills, through training (Schön 2000).

In line with other research, the majority of nurse and allied health middle managers shared a desire to improve their leadership, through training and support so as to be able to meet their workplace challenges (Carlström 2012; McConville and Holden 1999). Participants explained that although traditional training programmes have a place in adult training, leadership learning cannot be acquired solely through traditional training techniques (Parry and Sinha 2005; Russell and Kuhnert 1992). There was consensus in the data that much of the skill essential for effective leadership was learnt through communities of practice and mentoring.

Uhl-Bien (2006) claimed that leadership cannot be understood apart from the social systems within which it occurs. In line with this contention, a large part of how study participants perceived their role as leaders involved relations and interactions with employees. This is far from a single all-powerful leader. Networking emerged as a prominent feature of leadership. Participants reported that networking increased their intellectual confidence through sharing of experiences and finding new ways to handle challenging situations. While this is an important finding, yet it is congruent with Yukl’s (2010) and Uhl-Bien’s (2006) emphasis on the importance of relationships in many of the literature surrounding leadership. It is also indicative of the famous finding in Mintzberg’s (1973) study that showed that managers spend most of their time relating to others. In his research on the managerial roles and behaviours of several chief executive officers, professor of management Henry Mintzberg showed that managerial work may be described in terms of various roles defined as “organized sets of behaviors identified with a position” (1990, p.168). He argued that aspects of the leader role include both

the vertical relationships as well as those relationships outside “the vertical chain of command” (p.169).

Middle managers felt that communities of practice contributed to their well-being and to survival in their role. Besides being an important finding, it is also an important aspect of learning for middle managers in this study. When considering the building and co-creation of knowledge through mutual interactions of health workers in public health units in Canada, Kothari et al. (2011) similarly found evidence to suggest that public health workers recognised the support of communities of practice or networks in their everyday work realities. Findings from the present study highlight that tacit knowledge is built on so as to construct a shared understanding. This was gained through nurse and allied health middle managers’ interactions with each other, and has implications in translating knowledge gained into practice. Besides, communities of practice support groups and developmental relationships were reported to help hospital healthcare managers to act and to gain confidence in complex situations (Bergman et al. 2009). Participants demonstrated that learning and generating knowledge through practice were inherent features of communities of practice within organisations. It follows that taught leadership programmes and long-term support groups may complement each other as they bring together knowledge and practice (Tagliaventi and Mattarelli 2006; Brown and Duguid 1991). In contrast to these findings, Korczynski (2003, p.55) underlined that “communities of coping” amongst workers may act as direct resistance to management policies, making workplace situations more difficult for management intervention and control.

Furthermore, nurse and allied health middle managers claimed that support from communities of practice generated positive emotions, and helped them deal with anxieties. This is important as the emotional expression of leadership was significant in this study. Since hospitals have been described as “institutions cradled in anxiety” (Menzies-Lyth 1988 and Revans 1982, cited by Edmondstone 2011, p.15), study findings suggest that leadership development may indeed be focused to manage anxieties within “the turbulent health care workplace” (Edmondstone 2011, p.15), whilst support groups may contribute to healthcare middle managers’ emotional support in their everyday work (Bergman et al. 2009). Along similar lines, Korczynski (2003) argued that service workers formed communities of coping, an important part of what Hochschild (2003, p.114) called “collective emotional labor.” This was echoed by Theodosius (2006) and Putnam and Mumby (1993). They advocated that the sharing of emotional experiences builds interrelatedness and mutual understanding, positively affecting the workplace environment. Certainly, the present study findings indicate that collective forums helped healthcare middle managers to deal with stressful situations and survive workplace tensions (Menzie 1960).

It is evident that in this study, support from colleagues was a strong safety network emanating from communities of practice. As scholars have suggested, teamwork and networking were strategies that nurse and allied health middle managers employed as self-protection, providing a protective window in a particularly complex setting characterised by ambiguity (McPhail 1997). This study finding has also been recognised in recent research by Tong and Arvey (2015). They reported that managers handle workplace complexity through networking and encouraging managers to “volunteer true experiences” so as “to influence others’ understanding of an issue, and the actions and outcomes that follow” (p.668). Nonetheless, it needs to be highlighted that without opportunities for sharing feelings and experiences, and discussing organisational problems and other difficulties with other middle managers in similar situations, healthcare middle managers will feel increased role strain and will be unable to appreciate that they are not alone in their situations (McConville and Holden 1999). Consequently, it is not surprising that study participants expressed a need for collective group training “as a motivational force that can enable interaction in the face of diversity” (van der Vegt and Bunderson 2005, p.533).

In addition, mentoring was proposed by nurse and allied health middle managers as an exchange and feedback relationship for their leadership development. They believed that mentoring could help them increase their learning during their everyday work realities. Middle managers reported that mentoring could provide feedback and advice on their strengths and weaknesses, and also help them acquire new skills, attitudes and perspectives. Mentoring would help to facilitate learning, development, organisational commitment and also help middle managers to deal with stressful and challenging situations. This study finding provides support for Yukl’s (2010) assertion that mentoring provides 2 types of functions, “a psychosocial function (acceptance, encouragement, coaching, counseling) and a career-facilitation function (sponsorship, protection, challenging assignments, exposure and visibility)” (p.442). Nurse and allied health middle managers’ suggestions for leadership development have been recognised in other studies. McKenna et al. (2004, cited by Nilsson and Furåker 2012, p.107) observed that “mentoring by experienced leaders, is perceived to be effective for leadership development.” Yukl (2010, p.452), Parry and Sinha (2005) and Day (2000) recommended that leadership development experiences should include mentoring, besides formal training, practice experiences, feedback systems and leader-follower relationships. Similarly, Groves (2007) argued that indeed, a supportive organisational culture, feedback system, mentoring, networking and action learning, provide more effective learning for managerial employees in healthcare organisations. Furthermore, study findings suggest that mentoring programmes are more credible if they are supported by senior management. Certainly, senior managers are ideally placed to pass on their knowledge and prepare middle managers for succession planning through mentoring (Lee and Herring 2009, cited by Stringer 2014, p.116).

While the leadership and management training programme set the foundation for leadership development and training, nurse and allied health middle managers in this study recounted that mentoring and communities of practice could help them manage better the increasing complexity in healthcare, and facilitate the transfer of knowledge gained in training to practice. This finding implies that training is achieved through practice and feedback. Participants underscored that training of middle managers should include practical situations where skills may be practiced and developed, and feedback given on performance (Mintzberg 1990). They outlined the usefulness of feedback in increasing leadership development and leader performance, and reported that they learnt better in the context in which they were practising (van der Kam et al. 2014; James and Minnis 2004). These study findings are particularly significant because the underlying CVF provided a useful framework as a basis for the study participants so that they could better understand their various functions in paradoxical situations. It also helped them to think in different ways about the dynamic nature of their performance and how they operated under the burden of contradictory, competing and conflicting expectations (Viitanen and Konu 2009; DiPadova and Faerman 1993). Consequently, the underlying CVF helped nurse and allied health middle managers to identify from their perspectives what they recognized as complex leadership issues, and their training and leadership development needs in order to fulfil and respond to competing expectations required for good quality care in an acute healthcare setting.

5.6 Outlier comments

Atypical data will now be discussed in the context of this study and other academic studies. One research participant came up with divergent statements. Since he was the only participant to come up with outlier comments, it may be concluded that his views were not common. However, his insights helped to provide a richer source for further interpretation of data (Miles and Huberman 1994).

Stressful situations may have led this allied health middle manager to show evidence of selfish thinking. Similar to other middle managers, he reported lack of engagement and transparency by senior management. Unsurprisingly, this created a sense of uncertainty. However, the participant focused on his own interests, unlike the other participants who nonetheless exuded positive, altruistic thinking. This finding agreed with Weick's analysis of the Mann Gulch disaster. Weick (1993) revealed that when faced with personal negative outcomes, individuals may look for ways to take care of themselves, rather than focusing on the over-all picture.

Moreover, the low support from senior management resulted in the participant experiencing frustration, leading to low training activity vis-à-vis being open to learning. The participant revealed that he felt alienated from the organisation. This is what Carlström (2012, p.100) called

self-determined “sliding out” and “distancing” of middle managers to an “isolated position” due to undue pressure from balancing tensions and conflicts. Employees who lose enthusiasm for their work have also been described as the “working wounded” (McColl-Kennedy and Anderson 2002, p.548). Interestingly, the “sliding out” phenomenon was not supported by the other participants even though they revealed similar leadership perceptions. It appears that this middle manager became disengaged because he believed that he had no control over the work objectives. This may have happened because he did “not have sufficient management tools for managing the complex and sometimes conflict-filled environments that often characterise care organisations” (Carlström 2012, p.100).

The participant further disclosed that his hard work was not being compensated and he was denied promotions. Consequently, his attitude towards his role and the organisation became increasingly cynical and bitter. His comments were consistent with the findings reported by Thomas and Dunkerley (1999) in a 2-year study of middle managers in 50 organisations across both public and private sectors. These scholars warned that if middle managers felt that their efforts were not being paid off, they increasingly had negative attitudes that could lead them to opt out of their roles. This is especially true for those middle managers who “are still looking towards hierarchical career progression as the main reward for their continued commitment” (p.157), as appeared to be the case for this allied health middle manager.

The participant’s cynical attitude may also be attributed to his apparent authoritarianism and his exaggerated respect for power and order. It is possible that these characteristics afflict individuals in leadership positions (Gabriel and Griffiths 2002). “[I]nflated perceptions” of leaders’ favourable “attitudes, abilities and behaviour” may result in a positive self-image and high self-esteem. Such behaviours provide a sense of control in ambiguous and stressful situations but also, self-serving attributions, which hinder the individual’s relationship with others (van der Kam et al. 2014, p.268). This appeared to be happening with this participant.

In conclusion, a notable issue emerging from these divergent views is that it is important not to underestimate the significance of prolonged strains experienced by healthcare middle managers through workplace challenges, even though in this study, these divergent views may have possibly resulted from different personality characteristics. Middle managers’ career development and commitment to their position needs to be supported through training and leadership development. This is essential for middle managers so as to handle complexity within the healthcare context. Indeed, as affirmed by Quinn (1988), education and development may affect one’s management and leadership performance in addressing the varied challenges and role demands expected of managerial leaders as underlined by the CVF.

5.7 Limitations

There were a number of limitations to this research study. The research was positioned within a theoretical context, which provided an underlying framework for understanding the concepts essential to the study. Hence, the study started with the assumption that certain aspects of the leadership experience should be focused on. These were the healthcare context, the leadership perceptions of nurse and allied health middle managers, and middle managers' training and leadership development needs. The CVF informed the research study. Subsequently, a theoretical model was developed to reflect the characteristics of the study. These characteristics defined the study boundaries. Prior theorising risks the making of connections and may inhibit surprise discoveries (Charmaz 1990). Despite being a possible limitation, it was felt that this theoretical model adequately reflected the reality of participants and was best suited to advance knowledge on the leadership experience of nurse and allied health middle managers working in an acute healthcare setting.

Other limitations were related to the research methodology. The study used an exploratory design, with descriptive, interpretative and explanatory elements. A considerable part of leadership literature belongs to positivist traditions that discount personal experience, as qualitative work cannot be standardised and measured. To reveal its significant potential, this research required interpretation rather than statistical analysis. This may be regarded as a limitation. However, "personal experience is privileged above all else (including Plato's philosophy and science) as a source of knowledge" (Gabriel 2004a, p.70). Nonetheless, personal experience is "not an undisputed and unproblematic source of knowledge" (p.78).

Besides, the process of analysis and interpretation remains partially hidden from this final thesis document. This is a limiting factor because analysis and findings require evidence. Efforts to mitigate this limitation included inserting examples of manual coding of participants' transcripts, and sample descriptions of the themes, significant statements and their meanings within the appendix of the thesis document. This decision trail attempted to illustrate the process of analysis and interpretation to readers (Sandelowski 1986).

The research study does not make any claims in presenting neither a generalised nor conclusive picture of the leadership experience of nurse and allied health middle managers. The small non-random purposive sample of interviewees limits the representativeness and transferability of the findings. The sample was drawn from a single location, and since the study was conducted in an acute hospital, the results may not be applicable to other settings. Moreover, middle managers' positions in different contexts at various points in time shift constantly. Additionally, participants did not form a well-defined homogenous group and came from varied professional backgrounds reflecting a range of skills and experience. Participants also had varying degrees of

leadership and management backgrounds, as well as different levels of management and leadership training. Besides, the various sub-cultures could have artificially effected the findings irrespective of having all been subjected to the same leadership and management training programme. Furthermore, the 1 participant with divergent views may have actually represented a range of responses from potential respondents who did not participate in the study. In determining transferability of the research findings, one must consider the contextually driven experiences, the characteristics of the participants within this study and the potential participants who were not included in the sample. Study findings reflected the leadership perceptions and the training and development needs of nurse and allied health middle managers working in MDH. Whilst findings revealed similarity of perceptions and determination of similar leadership development needs of participants, they still need to be considered within this context. However, this does not mean that findings are not relevant in other settings.

The study is also limited in that it deliberately explored the views of nurse and allied health middle managers. My intention was to focus on these 2 groups of middle managers where a gap in research was identified. Besides, nurse and allied health middle managers are directly linked to patient outcomes, and are key in enhancing safety and quality healthcare. Nevertheless, hospitals are complex organisations, and their effective and efficient functioning depends on various employees (Hudelson et al. 2008). Including the leadership perceptions of non-clinical middle managers may have enriched the sample. In addition, adding the insights of peers, senior managers and subordinates may have given a broader understanding of leadership issues. Furthermore, data collection relied solely on participants' perceptions. There was no check whether their perceptions matched what they actually did in practice.

Another limitation resulted from the dynamics of the interview tool. The leadership perceptions of middle managers reflected what they chose to speak about and share. During the interviews, participants may have organised their own reality by selecting and pulling out leadership perceptions that were significant to them and that made sense to them in that particular moment in time. McCaskey (1991, p.139) observed that “[o]n the basis of our values and past experience, we perceive some events as potentially noteworthy, whilst most features of the world around us are relegated to the background. Otherwise, we would be overwhelmed by complexity and change.” Participants' responses may have also been biased by selective memory of events (Yukl 1989). This is because certain events may not have been valued enough by them, or else because they would have caused too much anxiety to speak about. Yet, the interview may have also triggered participants to reflect on experiences which would have otherwise remained unnoticed, silenced, forgotten or in the background. It is also possible that participants may have responded according to what they perceived I would have liked to hear (Polit and Hungler 1998). Consequently, I probed in a gentle but persistent manner so that the

respondents were drawn out of their comfort zones and predictable responses. Sometimes, participants also deviated from the research questions. When this happened, I tried to take them back to the questions.

Moreover, being a middle manager myself within the study setting, I acknowledged my role and influence on the study (Behi and Nolan 1995). I was predisposed to assuming that participants would supply knowledge that would confirm my very own understanding of leadership and I was tempted to select what aspects of participants' perceptions to listen to and describe, and in the process, transformed those perceptions (Sandelowski 2000; Field 1991). Collins and Cooper (2014) and Peredaryenko and Krauss (2013) acknowledged that confirmation bias is a very human tendency when searching for and interpreting data in ways that confirm the researcher's. However, I tried to use my own personal experience, knowledge and feelings as resources in analysing and interpreting what respondents said, allowing for richer and more dynamic data. Hence, the way scientific knowledge was generated depended very much on my own theories of knowledge and the interaction of my personal experiences with those of the participants (Stanley and Wise 1993). In addition, I used reflexivity so as not to impose my views on the participants' perceptions, and to analyse and interpret the data in an objective unbiased manner. Therefore, as an inside researcher I tried to shift between being a researcher and a middle manager "without causing noticeable disturbance to the research setting" (Greene 2014, p.7).

5.8 Implications for practice

The study participants shared their leadership perceptions aligned with the setting within which they worked. MDH, like any other acute healthcare setting is fluid and dynamic, shaping and influencing the functions of healthcare middle managers. This is not surprising given that healthcare organisations are embedded in a "historical, sociocultural, economic and political context which shapes the norms, values and expectations that in turn influence the structures and processes of the health-care system" (Buchanan et al. 2013, p.21). Leadership is very much dependent on various environmental and organisational conditions, hence the complexity of the contextual notion of leadership (Osborn et al. 2002). In addition, a healthcare environment has distinctive attributes, making healthcare leadership characteristically demanding and complex (Upenieks 2002). Thus, the way in which nurse and allied health middle managers in this study experienced leadership was influenced by the boundaries of the setting in which they functioned.

Consequently, before generalising the findings to other healthcare contexts, attention needs to be paid to the diversity of healthcare organisations within which nurse and allied healthcare middle managers work, the demands placed on them, the complexity affecting their roles, and middle managers' reactions to these complexities. Furthermore, middle managers' leadership

and educational backgrounds, attitudes, and their changing tasks and responsibilities may vary from one setting to another. The study was conducted in an acute hospital in Malta where the geographical and historical contexts may influence leadership practices of healthcare middle managers. It was beyond the scope of this study to examine differences in leadership practices across countries. However, it is worth noting that Malta possesses specific characteristics. Malta has gone through the stages of gaining independence, becoming a Republic and joining the European Union. Yet, Malta still suffers from an island mentality. Prior to independence in 1964, the Maltese were ruled and led by various nations across centuries. After that, they had to learn how to lead themselves (Micallef 2011). This sheds light on the peculiarity of Malta and the impact this may have had on the leadership perceptions of healthcare middle managers participating in the study. Leadership practices, informing participants' performance, development and training may be different from leadership practices of other healthcare middle management populations. Still, striking similarities were found in study findings reviewed in the literature sources across populations from the mostly European and North American countries, and countries from the Asia-Pacific region. This may be because the Maltese culture reflects the various societies that have come into contact with Malta throughout the centuries. Hence, the consistent results across multiple studies, various settings and diverse populations may validate the applicability of issues raised by nurse and allied health middle managers in this study.

Study findings have shown that nurse and allied health middle managers are ideally positioned to make a contribution to the development of service delivery. Rather than being an adjunct to management they have a leading role within the healthcare context. Nurses and allied health professionals form 2 of the largest groups of healthcare professionals. This underlines the importance of their roles as managers and leaders in healthcare organisations (Gifford et al. 2014). It also has implications in that further recognition and support of their role and leadership within MDH and other healthcare organisations are indicated, particularly in view of the range of emotions and organisational challenges experienced. Hence, hospital and senior management must ensure the creation of a supportive organisational environment that contributes to the growth and development of nurse and allied health middle managers through opportunities for sharing feelings and experiences.

The study has also demonstrated that nurse and allied health middle managers can make a contribution to research. Their accumulated expertise and experience is untapped in terms of mobilising healthcare leadership training and development needs. Their perceptions and experiences must be listened to by the senior managers and trainers in order to enhance the organisations' understanding of how best to support them in their roles. In their positions, middle managers were very often overwhelmed by the contradictory demands of leadership and intense emotions. On the basis of the findings presented in Figure 4.2, the importance of middle

managers' leadership experiences, the sharing of experiences with colleagues and self-directed knowledge were clearly evident upon their learning process. Middle managers demonstrated a strong need to apply what they had learnt in practice, and also, to learn things that were of personal relevance.

Experience and having control over their own knowledge were rich resources for participants' learning. This has important implications for leadership training programmes in that the middle managers may partly determine the direction that learning takes. Hence, their learning process can to a certain extent be governed by their own needs and goals through self-directed learning and knowledge. Consequently, there needs to be inclusion of middle managers in planning future leadership training and development programmes through a partnership approach with senior managers and trainers. Middle managers' participation in their own learning should be placed on the organisational agenda so that training is directed when and where it has the greatest impact on healthcare workers. Nurse and allied health workers also need specific training to support their preparation and transition to the middle management role. Hence, training should be designed so that middle managers may be able to utilise their abilities, expertise and experience more effectively, and have the knowledge and skills to lead across ambiguous situations and to deal effectively with conflicting emotional demands. Clearly, such training programmes would provide a picture of discerning middle managers able to maintain a firm balance amid the ongoing contradictory and paradoxical demands of their position within the acute healthcare setting. This would help them to build on their own leadership experience and transfer it to their own workplace situations.

Moreover, nurse and allied health middle managers suggested that leadership development should be supported through a combination of taught lectures, mentoring and communities of practice professional development approaches in order to address their training and leadership development needs. Peer interaction and communities of practice support groups were reported to be of particular benefit to nurse and allied health middle managers, especially in helping them to cope with and balance the workplace demands and contradictions within their role. Networking also functioned as an informal type of social and emotional support. This is because relationships with superiors, peers and subordinates formed the foundation of what middle managers did. These proposals should help healthcare middle managers have the necessary support by senior management and trainers so that they are able to exercise leadership in complex, yet in lesser stress-free ways.

Study findings likewise suggest that emotional expression was inherent in middle managers' role. Although emotional complexity of participants' leadership experience emerged from the study, to date there has been little attempt to help middle managers in proper emotional management and support. When referring to the unrealistic expectations generating anxieties on

staff within healthcare systems, Gabriel (2015a, p.619) contended that “[u]nless we develop ways of containing these anxieties without denying them or viewing them as indicators of weakness and failure, health workers will continue to be confronted with impossible and damaging demands.” Therefore, senior managers and trainers should consider introducing communities of practice long-term support groups and mentoring in future leadership training and development courses so that middle managers are able to understand their emotions, use emotions to engage in positive thinking, manage and reframe the negative emotions, and also support emotional relationships. Emotions, in turn, would help middle managers to understand their leadership and their capacity to perform in healthcare contexts, which are very often characterised by complexity, contradiction and paradox, as underlined by the CVF.

Nurse and allied health middle managers placed an emphasis on the importance of behavioural complexity and the application of good judgment to apply those behaviours as the situation dictates (Lawrence et al. 2009; Hooijberg et al. 1997). Appropriate behaviours are particularly important in addressing the competing demands and roles expected of healthcare middle managers, helping them not lose their enthusiasm for work, and preventing them from “sliding out” of their role (Carlström 2012, p.100). Hence, formalising mentoring and communities of practice approaches in the workplace would respond to, and meet nurse and allied health middle managers’ needs and promote learning. These leadership development initiatives would engage middle managers in experiential learning, problem solving, critical thinking and self-reflection, based upon in-context experiences relevant to them. This would in turn be translated into a more positive leadership experience.

Consequently, study findings would be helpful to senior managers and trainers to inform practice and future research, namely through the planning, development and evaluation of leadership training and development programmes. This is held against the belief that leadership and management training is essential for healthcare middle managers so as to ensure that they have the knowledge, attitude and skills required to balance conflicting demands across ambiguous situations, and to address the emotional demands associated with their leadership experience. Indeed, in this study, the CVF provided a useful framework to answer the research questions because it helped participants to understand better the paradoxical characteristics of leadership and the leadership competencies required for various situations in acute healthcare contexts (DiPadova and Faerman 1993). Therefore, middle managers were able to suggest solutions to support their development and self-care. The findings should also contribute towards the development of leadership practice in nurse and allied health middle managers’ roles, which would in turn translate into enhanced management of staff and patients, and better quality healthcare. Subsequently, learning would be promoted “at individual, group and organizational levels” (Gabriel and Griffiths 2002, p.214).

The aim of a Professional Doctorate in Health is to make a contribution to both theory and practice in a particular field and develop professional practice by making a contribution to professional knowledge (Lee 2009). This thesis on the leadership experience of nurse and allied health middle managers in MDH should contribute to the theory and practice of leadership by providing a current body of knowledge that can inform practice and future research relevant to nurse and allied health middle managers in Malta and beyond. Evidence gathered from this research study was specifically sought from nurse and allied health middle managers working in an acute health setting. Consequently, this thesis and its recommendations are informing the evidence base for the senior managers and trainers so as to influence the practice and learning of healthcare middle managers.

5.9 Implications for further research

The limitations and the findings of the research study set the stage for future research on exploring the leadership experience of other middle managers. Nurse and allied health middle managers at MDH do not work in a vacuum and further research into the leadership experience of non-clinical middle managers and healthcare middle managers working within other healthcare settings, like community care and primary healthcare would include additional, possibly divergent views and provide comparable leadership experiences. This would also build upon the present study's contribution, increase knowledge in the practical application of leadership practice, and contribute to transferability of findings.

The study has shown encouraging evidence of the effectiveness of communities of practice support groups, and positive views on mentoring programmes. Findings provide support for further research with larger samples of healthcare middle managers, as well as non-clinical managers on the role of communities of practice development approaches and mentoring programmes, to support training of middle managers towards effective and efficient delivery of healthcare services. In addition, further research on the training requirements and leadership development needs of healthcare middle managers would explore whether training deepens their understanding of their own practice, helps them to confront conflicting and complex situations, and manage the emotional demands that are critical to middle managers' leadership experience. Further exploration into training, possibly, through quantitative research would obtain a broader understanding of the leadership experience and development needs of healthcare middle managers.

Furthermore, findings were based on participants' self-reports and voices only. Nurse and allied health middle managers' leadership perceptions are important but they may not be complete on their own. Besides interviewing middle managers, future research should gain third party corroboration. Deeper insight should be gained by doing ethnographic research in the

participants' work environment, and interviewing participants' subordinates, peers and superiors using a 360-degree feedback approach. This multi-method approach would bring the researcher closer to the workplace realities of middle managers, give the researcher a better understanding of middle managers' leadership perceptions and developmental needs, and a broader analysis of issues.

This research raised questions to be explored and the innumerable dimensions in understanding the leadership experience of nurse and allied health middle managers within their healthcare context: value of care in leadership, loss of control, resilience and unrecognised contribution amongst others. These should provide the background in which to approach additional qualitative research in the study of the leadership experience of healthcare managers, the ultimate aim being that their leadership experience is improved in the best interest of quality patient care.

5.10 Thesis summary

It has been established that nurse and allied health middle managers play a central role in health service delivery. Therefore, understanding middle managers' leadership perceptions and development needs is imperative for quality healthcare. Yet, the literature regarding the leadership experience of nurses and allied health professionals in middle management roles from their perspective is not extensive. The present study sought to address this gap by presenting a qualitative study involving 21 nurse and allied health middle managers working within the acute healthcare setting of MDH. So as to explore their leadership experience, the study was built on 3 interrelated concepts. These were the healthcare context, the leadership perceptions of nurse and allied health middle managers, characterised by middle managers' role, emotions and interpersonal relationships; and middle managers' training and leadership development needs, reflected through their preparation for their role, effectiveness of training, and improving professional development practices. The CVF was used to guide data collection. The 3 concepts and the CVF were brought together into a theoretical model that was pertinent to this study, and helped to uncover the complexities of middle managers' positions and the innumerable dimensions of their leadership experience.

Through semi-structured interviews, and using an exploratory approach with descriptive, interpretative and explanatory elements, nurse and allied health middle managers' experience of leadership was captured, bringing awareness and understanding of their direct experience when working within the complex and dynamic tensions of an acute healthcare organisation. Participants' perceptions of their leadership training and development needs were also explored. Whilst this qualitative study confirmed many of the findings from previous research, it brought fresh insights to previously known phenomena pertaining to the leadership experience of middle

managers. The study has presented a picture of 4 inter-related findings drawn from the data analysis that to date have not been determined and documented in one specific context, in one specific population. Moreover, the findings revealed positions of participants in terms of the complexity, contradictions and paradox in the CVF.

It is evident that the outcome from this study is knowledge that may change practice and future research (Mayan 2010). The findings highlight the importance of nurse and allied health middle managers in a complex acute healthcare setting, and confirm that their leadership experience is complex and very often influenced by contextual and organisational factors. The emotional elements of leadership and the continual balancing required to manage conflicting and contradictory situations were central features of the findings, and mainly featured so as to safeguard organisational and personal interests. This balancing provoked a very challenging and potential distressing situation for middle managers, which is widely documented in the literature. It underlines the need for organisations to recognize the importance of workplace emotions and demands.

The study contributes insight into nurse and allied health middle managers' emotional expression of leadership within an acute healthcare context. This was revealed through the interview accounts when participants spoke at length about their leadership perceptions, and identified their expressed and visible emotions, but also, other hidden emotions. The emotional expression of leadership manifested the contribution and role of healthcare middle managers in handling workplace and role complexity, inherent in addressing the competing demands and roles expected of them in their everyday organisational realities. This was revealed not only through caring for their staff and patients, but also through their contribution in improving organisational outcomes. Certainly, the CVF helped to guide the interview questions, and made it easier for middle managers to understand the complexity of effective leadership.

The research emphasises the need to ensure that all current and future healthcare middle managers are adequately prepared and trained for their role. It also provides insight into nurse and allied health middle managers' leadership development needs to enhance their motivation and commitment within their organisation. Healthcare middle managers underscored the immense value of communities of practice professional development approaches and mentoring programmes in offering a valuable contribution to their learning and emotional support, and in the creation of trust and group cohesion. Middle managers recommended that communities of practice professional development approaches and mentoring programmes would contribute towards their self-directed learning, growth, survival and success. Training did not enable middle managers to deal with the complexities and contradictions that the CVF portrays but co-support amongst middle managers did, suggesting that middle managers should not be studied

in isolation, but interprofessional relations should also be considered. This has implications and reveals recommendations as to where and how resources for the leadership development of healthcare middle managers should be invested by the organisation. These findings mean that healthcare organisations have to refocus their training efforts so that nurse and allied health middle managers' efforts are acknowledged and their important work in the middle supported.

In conclusion, this study has demonstrated that nurse and allied health middle managers can make a valid contribution to inform practice and research. They provided insight into how they lead inside an acute hospital, how the organisation may support them, and how they may contribute in planning future leadership and development programmes. The research helped to unpack the dynamic and contradictory nature of the leadership experience of middle managers across the dimensions of the CVF, underlining the paradoxical nature of middle managers' role demands, and the emotions experienced by them in leadership. Research led to knowledge generation that exposed the importance of understanding the specific realities of the leadership experience within an acute healthcare setting and within a specific population, rather than simply extrapolating and transferring findings from one context to another. Whilst the context may not be unique, it is certainly distinctive. This qualitative research was valuable in generating such a realisation and appreciation. Indeed, the study findings explicitly portray the value of nurse and allied health middle managers in their ability to lead within their organisation, through their role in seeking a balance to achieve good quality healthcare outcomes within an acute healthcare setting. Emotions helped to shape the leadership experience. This is exemplified through one of the participant's statements:

Abigail: There are always 3 points of consideration...There's the patient, the staff and the organisation. It's a triumvirate...From a patient point of view, that is our *raison d'être*...We exist because there's the public, the patient, the population and that's what our job is. Bottom line is that...and it's the staff who is providing the service. And you cannot expect to give a good service to patients if you don't look after your staff...it means respecting them, putting a value on them, training them and understanding what service provision means to them....the job has got to be done but it's got to be meaningful to staff. They have to feel good about doing it...And then you've got the organisation because I think we have a huge responsibility to the organisation that we represent and the wider health service. We are all ambassadors of our organisation. I'm being paid by my own organisation and I have an obligation to it. And yes, I feel it is important to imbibe and sustain and improve the feeling of pride in what one does, and you know, yes, we're treating patients at Mater Dei. The feeling is fantastic. I'm part of the health service. It's a good feeling!

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Appendices

Appendix I: Job descriptions of nurse and allied health middle managers

GRADE	CHIEF NURSING MANAGER
OBJECTIVE OF THE POST	To oversee the management of nursing services within an entity to ensure the delivery of a high standard of nursing service to all clients.
MAIN RESPONSIBILITIES	<ul style="list-style-type: none"> • Provide leadership and direction for qualified nurses, support workers and other employees across clinical settings within his/her healthcare entity. • Assure the availability of adequate and appropriate resources for a continuous and consistent delivery of nursing care, taking into account the advice given by the Senior Nursing Managers. • Assume responsibilities involving the supervision and management of a health facility. • Assess current policies and procedures related to nursing practice in his/her healthcare entity. • Generate new ideas for improvement taking operational issues into account and acting in line with standards approved by the Director of Nursing. • Assume a key role in the motivation, development and evaluation of staff working within the assigned health facility/unit. • Establish and track quality improvement indicators and other information concerning services and care to ensure that resources are available to provide quality services and on-time performance consistent with standards. • Ensure that business plans, human resource plans, and performance audits are compiled in time for the assigned health facility. • Take a lead role in health promotion and health education activities. • Initiate and support the necessary research that will eventually sustain the delivery of evidence based practice. • Support a clinical environment that facilitates change and introduces innovative efficient care structures and processes that are beneficial to clients and the organisation. • Use available budgets to ensure quality care and the delivery of cost effective services while monitoring all personnel and supply costs at departmental level. <p><i>Confidentiality: The post-holder is required to respect the confidentiality of matters relating to the clients</i></p>

GRADE	SENIOR NURSING MANAGER
OBJECTIVE OF THE POST	To oversee the management of a number of wards/units in order to ensure the delivery of a high standard of nursing service to a number of clients.
MAIN RESPONSIBILITIES	<ul style="list-style-type: none"> • Comply with standard policies and procedures as determined by the Chief Nursing Manager within the specified clinical department. • Supervise and manage a specified clinical department within a health facility including planning, organising and integrating various functions of the department. • Responsible for providing the Chief Nursing Manager with advice on the resources required for a continuous and consistent delivery of nursing care within his department. • Provide visible and accessible site leadership and direction creating a climate where qualified nurses, support workers and other employees deployed in clinical settings falling within his/her department are empowered to be effective in their role. • Assess care needs and evaluate programmes of care as part of the multidisciplinary team ensuring the delivery of high quality care to clients within a specified clinical department. • Ensure cost effective staff utilisation and deployment in line with workload requirements within the specified clinical department. • Support, supervise and carry out performance appraisal of the Nursing Officers. • Deputise for the Chief Nursing Manager as may be required. • Take a lead role in health promotion and health education activities. • Initiate and support the necessary research that will eventually sustain the delivery of evidence based practice. • Initiate and participate in the collation of data in connection with a quality improvement initiative. • May also participate as audit officers in connection with internal and/or auditory review. • Support a clinical environment that facilitates change and introduces innovative efficient care structures and processes that are beneficial to clients and the organisation. • Use available budgets to ensure quality care and the delivery of cost effective services while monitoring all personnel and supply costs at departmental level. <p><i>Confidentiality: The post-holder is required to respect the confidentiality of matters relating to the clients</i></p>

GRADE	PROFESSIONAL LEAD ALLIED HEALTH PRACTITIONER
OBJECTIVE OF THE POST	To strategically plan, develop and monitor the 'Allied Health' Service in Malta and Gozo in relation to existing and proposed health care policies.
MAIN RESPONSIBILITIES	<ul style="list-style-type: none"> • Establish and maintain a professional practice framework in the discipline. • Establish national objectives for the relevant services in line with national health policy. • Ensure all staff working in the service across the organisation receives a high standard of professional development support. • Plan and develop the specific allied health service in accordance with the changing health needs of the country by recommending appropriate policies for the service. • Monitor all relevant services and submit relevant statistics to the appropriate authorities. • Act as a professional advisor to the Government (through the Health Division) and the relevant educational bodies. • Develop quality assurance indicators in all areas of the service to ensure nationwide quality of services (private and public). • Be responsible for the effective and efficient deployment of staff in consultation and liaison with the Service Managers and CEO's of the entity. • Decide on the skill-mix and grade-mix required by the service for optimal functioning while at the same time allowing for staff development. • Co-ordinate the activities of the various units and areas through regular contact with the senior staff. • Be aware of health trends and policies both locally and abroad. Regular up-dating is essential. • Deal with complaints and suggestions from the public, staff and other professionals within the organisation. • Encourage research activities in the clinical and managerial aspects of the service. • To take an active part in the education of staff and students, within and outside the professional discipline. • Maintain a high level of communication with the heads of other disciplines and relevant policy making authorities. • Introduce innovative methods and approaches with respect to patient care and services.

	<ul style="list-style-type: none"> • Ensure that services are used with maximum efficiency to produce the most effective outcomes. Cost-effectiveness and cost benefits should be major considerations. • Motivate all staff within the service. • To facilitate the implementation of changes within hospital departments, sections and units. • To draw up minimum standards and guidelines for the specific allied health care service. <p><i>Confidentiality: The post-holder is required to respect the confidentiality of matters relating to the clients</i></p>
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GRADE	ADVANCED ALLIED HEALTH PRACTITIONER
OBJECTIVE OF THE POST	To assist the Professional Lead Allied Health Practitioner and Service Manager in the planning and management of the specific Allied Health Service. To plan, develop and monitor the service in relation to existing and proposed health care policies.
MAIN RESPONSIBILITIES	<p>Professional and Clinical</p> <ul style="list-style-type: none"> • Manage the provision and delivery of the allied health service in specific areas ensuring a high standard of service delivery. • Take on the responsibility for all staff, students and helpers working in the service. • Undertake staff tutoring to ensure and encourage staff development and research. • Liaise effectively with appropriate medical and other disciplines in the management of patients. • Initiate and develop new ideas and methods and to encourage other staff to participate. • Act as an advisor to the government (through the Health Division) and the relevant educational bodies. • Monitor and submit relevant statistics to the appropriate authorities. • To develop high standards of clinical practice. • To contribute to a structured process for education of colleagues. • To undertake research in a particular area of expertise. • To demonstrate evidence based practice through the process of clinical reasoning and decision making. <p>Administration and Managerial</p> <ul style="list-style-type: none"> • Be responsible for the management of specific allied health service. • Develop the specific allied health service in accordance with established policies. • Liaise with other senior staff within the service as well as the Professional Lead Allied Health Practitioner and Service Manager to promote and develop co-ordinated services of high standards. • Assist the Professional Lead Allied Health Practitioner and Service Manager in the effective and efficient deployment of staff and ensure that the allied health service is used with maximum efficiency to produce the most effective outcomes.

	<ul style="list-style-type: none"> • Deal promptly with complaints and suggestions from the public, principal staff and professionals within the organisation. • Ensure appropriate action is taken in the event of incidents. • Deputise and carry out any other duties as requested in response to the exigencies of the service. <p><i>Confidentiality: The post-holder is required to respect the confidentiality of matters relating to the clients</i></p>
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Appendix II: Data protection clearance

Aquilina Vanya at MDH

From: Data Protection at MDH
Sent: Wednesday, October 24, 2012 4:51 PM
To: Aquilina Vanya at MDH
Subject: RE: request to access staff members

24th October 2012

Dear Ms. Aquilina ,

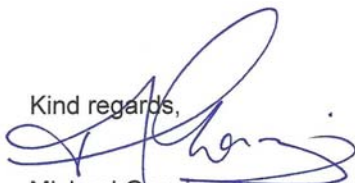
With reference to the above-named study, this is to confirm that, on the basis of the documentation you submitted, from the MDH data protection point of view you have been cleared to proceed with your study.

You are requested to submit a copy of your findings to this office at the end of your study.

Please remember that in no way should you retain any personal details you obtain from your research and this should be destroyed at the end of your study and you should abide to the provisions of the Data Protection Act at all times.

Good luck with your study.

Kind regards,



Michael Gonzi
Data Protection Officer,
Mater Dei Hospital
Tel: (+356) 2545 5334
Email: dataprotection@mdh.gov.mt

Appendix III: Ethical approval from REACH, University of Bath, UK

REACH Feedback

James Friedlander-Boss [J.D.Friedlander-Boss@bath.ac.uk]

Sent: 21 March 2013 13:20

To: Aquilina Vanya at MDH

Dear Vanya,

Full title of study: The leadership experience: the perceptions of middle managers working within the principal acute general hospital in Malta

REACH reference number: EP 12/13 36

The Research Ethics Approval Committee for Health (REACH) reviewed the above application at its meeting held on 20th March 2013.

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion of the above research on the basis described in the application form and supporting documentation.

The committee did suggest that as there is only a need for 20 participants, you may need to write to those who aren't needed thanking them for their interest.

Please inform REACH about any substantial amendments made to the study if they have ethical implications.

Kind Regards

James Friedlander-Boss

Department Co-ordinator

Appendix IV: Ethical approval from UREC, Malta

L-UNIVERSITÀ TA' MALTA

Msida - Malta

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UNIVERSITY OF MALTA

Msida - Malta

OFFICE FOR HUMAN RESOURCES
MANAGEMENT & DEVELOPMENT

25th April 2013.

Ms Vanya Aquilina
Physiotherapy Department
Mater Dei Hospital
Tal-Qroqq
Msida MSD 2090

Dear Ms Aquilina,

I am pleased to inform you that UREC has approved your request to carry out your research:
The Leadership Experience: The Perceptions of Middle Managers Working Within the Principal
Acute General Hospital in Malta.

Yours sincerely,

Rev Paul Pace
Chairperson
University Research Ethics Committee

PARTICIPANT INFORMATION SHEET

Title of Project: **The leadership experience: the perceptions of middle managers working within the principal acute general hospital in Malta**

Introduction

I am Vanya Aquilina, a senior principal physiotherapist at Mater Dei Hospital. I am reading for a Professional Doctorate in Health within the School for Health, University of Bath, UK. The referred programme of studies incurs a research study and I am interested in focusing my research work on the leadership experience of middle managers working within Mater Dei Hospital. I will be exploring the leadership views and experience of middle managers in an attempt to contribute towards the enhancement of knowledge and to make recommendations towards the development of practice of leadership in healthcare services in Malta.

Purpose of the research

The health sector throughout the world is continually going through rapid and dynamic developments in response to both internal and external forces of change. Middle managers have a contribution to make in influencing performance, individual wellbeing, quality of patient care and clinical outcomes towards excellence in practice.

The study will focus on an area which as yet remains unexplored in Malta. Insights into the perceptions of middle managers will be explored through the construction of participants' leadership experiences. The research will add to the understanding of middle management leadership in a complex health and professionalised context

Your participation

You are being invited to take part in this research because you are a middle manager working within Mater Dei Hospital and your experience can contribute much to my understanding and knowledge of leadership. Your participation in this research is entirely voluntary. It is your choice whether you participate or not. The choice that you will make will have no bearing on your job or any work-related evaluations and reports. You may change your mind later and stop participating even if you initially agree to participate.

Procedure

If you accept you will be asked to participate in an interview with myself that will take about an hour. The interview questions will be given to you one week prior to the interview so that you will have the opportunity to consider your responses. During the interview, I will sit down with you in a comfortable place of your choice. You do not have to answer any question or take part in the

interview if you feel that talking about some of the topics makes you uncomfortable. You do not have to give me any reason for not responding to any question, or for refusing to take part in the interview.

Please be aware that during the interview unanticipated and unpredictable disclosures may emerge. Do consider the possible impact of your disclosure. In situations where events associated with malpractice or illegal activities become apparent, you have the right to withhold information and to withdraw at any time. Please do understand that under these circumstances the promise of confidentiality does not hold, and such cases will have to be reported.

Benefits

Your participation will help the understanding of leadership within the specifics of middle management in a highly professionalised context. The research will also contribute towards the enhancement of knowledge and development of leadership practice in healthcare services in Malta. As such it may be of benefit to you personally as well.

Confidentiality

No one else but me will be present during the interview. The information that I will collect from this research project is confidential, and no one else will have access to the information documented during your interview. I will make notes and the entire interview will be audio recorded, but no one will be identified by name on the recording. Any information about you will have a code on it instead of your name. I will be the only person who will know what your code is. It will not be shared with or given to anyone. The raw material will be available only to me and I will lock the information up with a lock and key. Data will be stored electronically and on paper records until all information is collated, documented, reported and published up to a maximum of five years. Then paper records will be disposed of and electronic records will be deleted. Interview recordings will also be destroyed.

Sharing the results

Nothing that we discuss during the interview will be attributed to you by name. After transcribing the interview, I will get back to you and give you the opportunity to go over the transcript and verify if it reflects your own perceptions. You will also be asked to provide additional feedback on how you prefer to have your data handled. I will ask you to give your consent so that I may use quotes from your interview transcript. You may decide that you will not share specific pieces of your data directly as quotes so as to ensure that you are not identifiable. In this case, I will edit the quotes so that you are not recognisable, but at the same time, I will negotiate with you on how to preserve the data as much as possible so that I will still be able to derive meaning from these quotes.

Who to contact

If you have any questions, you may ask them now or later. If you wish to ask questions later, or have a concern about any aspect of this study, you may contact me as per contact details below.

This research has been reviewed and has received ethics clearance by the Research Ethics Approval Committee for Health, University of Bath, UK and by

the University of Malta Research Ethics Committee. The tasks of these two committees are to make sure that research participants are protected from harm. The proposal has also been approved by the Data Protection Officer, Mater Dei Hospital.

Researcher contact details:

Vanya Aquilina
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CONSENT FORM

Title of Project: **The leadership experience: the perceptions of middle managers working within the principal acute general hospital in Malta**

This research plan has been reviewed and has received ethics clearance by the Research Ethics Approval Committee for Health, University of Bath, UK and by the University of Malta Research Ethics Committee. The tasks of these two committees are to make sure that research participants are protected from harm. The proposal has also been approved by the Data Protection Officer, Mater Dei Hospital.

I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. The scope of the study, together with what will be required of me as a participant have been fully explained to me.

I am aware that I may put forward any questions whenever I want. I understand that my participation is voluntary and that I may withdraw my participation at any time without furnishing any explanation, and without suffering any disadvantage whatsoever.

I am also aware that confidentiality will be maintained by the researcher in the analysis and reporting of the results. Data will be stored electronically and on paper records until all information is collated, documented, reported and published up to a maximum of five years. Then paper records will be disposed of and electronic records will be deleted. Interview recordings will also be destroyed.

I, the undersigned, hereby agree to participate in this study on the leadership experience of middle managers working within Mater Dei Hospital.

Name of Participant

Date

Signature

Vanya Aquilina

Date

Signature

Prof Yiannis Gabriel

Date

Signature

Researcher contact details:

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POST- INTERVIEW CONSENT FORM

Title of Project: **The leadership experience: the perceptions of middle managers working within the principal acute general hospital in Malta**

It is my goal and responsibility to use the information that you have shared responsibly. Now that you have completed the interview, I would like to give you the opportunity to provide additional feedback on how you prefer to have your data handled. Please check one or more of the following statements:

___ I verify that the interview transcript is an adequate reflection of my interview.

___ You may share the information just as I provided it; my real name will not be used.

___ You may share the information I provided; my real name will not be used. Please edit quotes that might make me identifiable to others. In particular, it is my wish that the following specific pieces of my data will not be shared directly as quotes (describe this data in the space below). However I understand that you will be preserving the data as much as possible so that you will still be able to derive meaning from these quotes.

____You may contact me if you have any questions about sharing my data with others. The best way to reach me is (provide phone number or email):

____ Name of Participant	____ Date	____ Signature
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____ Vanya Aquilina	____ Date	____ Signature
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____ Prof Yiannis Gabriel	____ Date	____ Signature
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**MINISTERU GHAS-SAHHA,
L-ANZJANI U KURA FIL-
KOMUNITÀ**



MALTA

**MINISTRY FOR HEALTH,
THE ELDERLY AND COMMUNITY
CARE**

Uffiċċju tas-Segretarju Permanenti

Office of the Permanent Secretary

Leadership & Management Skills and Values Course

DETAILED OUTLINE

This 60-hour internally organised course for managers across the Ministry for Health, the Elderly and Community Care (MHEC) provides an opportunity for course beneficiaries to focus on the principles of leadership and management from both the theoretical and practical aspects. The course employs theoretical concepts and models, coupled with real life experiences of leaders within MHEC to facilitate and encourage personal and professional development within leadership as well as develop the potential that exists within each participant. Such an opportunity and investment adds value at both the individual leader level as well as the employees for whom the leader is responsible and accountable for. The course is based on both a constructivist and a transformational approach.

Course Outline

The course aims to bring about a systematic change at the intra-personal and inter-personal skills level from an individual, team and organisational level. This is achieved by initially facilitating optimal employee performance and satisfaction whilst gradually developing the ability within beneficiaries to address the complex needs that surface within a team and an organisation.

The course also aims to improve the human processes through which managers get their work done since the quality of the result is often directly related to the quality of the process used to accomplish such results given that organisational development is task-oriented.

Theory and practice are explored simultaneously throughout the course. Leadership theories will be covered with special emphasis made on their relevance to the full MHEC context. Real life experiences will be introduced throughout the course to provide the beneficiaries with the opportunity for in-depth application, implementation, reflection and review. Moreover beneficiaries will have the opportunity to be addressed by a range of colleagues willing to share their long term experience, practice and knowledge in specific and focused topics in different fields of leadership and management.

A reflective journal is required to be kept by the beneficiaries and entries are to include plans to develop one's own leadership potential and implementation. The latter is given special attention and direct reinforcement.

Whilst leadership as a stand alone topic is given priority, management skills and theory are also addressed during the course.

Course Benefits and Main Learning Outcomes

At the end of this 12-session 60-hour experience, beneficiaries will be able to:

1. Define leadership and management, and appreciate how they can be applied at the intra-personal, inter-personal, team and organisational level;
2. Understand value generation and success factors for optimal roll out and implementation of leadership and management skills and values across MHEC;
3. Determine what is necessary to motivate and engage staff;
4. Determine what is necessary to lead teams and integrate this with the day to day management;
5. Enhance and develop new skills in communication and decision making whilst taking into consideration the benefits of negotiation, managing up and conflict management;
6. Become adept at appraising themselves and others by assessing the leadership traits and qualities whilst learning how to also manage challenging emotions and difficult behaviours, influencing attitudes and values on an individual, team and organisational level;
7. Appreciate the importance of organisational culture and understand the role that attitudes play in establishing it;
8. Develop the skills needed to deal with diversity.

Course Content

PART 1

Introduction and objectives

Leadership – role, skills and styles (Leadership grid)

Leadership Theories (Collaborative, Transitional, Visionary and Situational Leadership)

Orientation to the relationship between leadership and management theories

Leadership and power

Leadership and Management (authority vs. responsibility, delegation vs. acceptance)

Intrinsic Motivation

Principles of motivation, theories of motivation and their application

Motivation through Goal Setting

Challenges for leadership in the MHEC workplace

Self Care

Taking care of the physical, emotional, mental and spiritual aspects
Self appraisal of own competencies
Be realistic about one's competence in management
Be able to identify the potential competence in others
Self actualisation in the team
Challenges for Effective Self care and Motivation

Communication

Basics of effective Communication
Barriers to Communication
Verbal and Non-Verbal Communication
Active Listening (Aggressive Listening)
Pragmatics
Challenges for Effective Communication

Leading with Emotional Intelligence

What Is Emotional Intelligence (EI)?
Understanding Yourself (Your Feelings & Emotions, Emotions Diary)
Dimensions of Emotional Intelligence (Self-Awareness, Self Management,
Understanding the Emotions in others, Managing Relationships)
Emotional Intelligence - Self Evaluation (Questionnaire) Emotional Intelligence &
Leadership
Who Am I As A Manager? (Internal & External Dimensions)

PART 2

Effective Delegation and Monitoring

What is Delegation and why delegate
Benefits of delegation for staff
Objective setting
Guidelines for setting SMART Objectives
Monitoring and Control

Establishing the Team

Team Building Process (Purpose, Organisation, Process, Culture & Influence)
Dealing with internal and external politics
The team leader as a facilitator, a mediator and a negotiator
The role of leader as the team matures
Ensuring a high performance team
Understand how the team function fits in the organisation
Reports on the team performance
Effectively communicate team performance related issues to all levels of the organisation
Hold productive one-to-one meetings

Ethics, discipline and conflict

Discipline and Conflict Management
Raising the standard of negotiations, persuasion and influencing
Improve ability to reach win/win outcomes through influence and persuasion

Problem Solving and Decision Making

Identifying the problem
Techniques for developing alternatives
Getting consensus
The leader as a problem solver
Thinking and Decision making processes (Decision- matrix)
The 3 D model – Debate, Discuss, Dialogue

Occupational Health and Safety

To Introduce BENEFICIARIES to the concepts and principles of OHS
To raise awareness on OHS issues
To familiarize BENEFICIARIES with priority issues, including legal responsibilities

Spiritual Intelligence

Why would we look for God in our work?
Spirituality and Religion Correlations
Issues that we have to deal with (aloneness, death and dying, meaning of life, freedom and responsibilities)

Developing Others

Coaching and Mentoring
The coaching and mentoring cycle
Pre requisites for coaching and mentoring
The coach and mentor as counsellor
Coaching and mentoring for performance

PART 3

Medico-Legal Issues

Dealing with complaints and claims
Appreciate basic elements of risk management and safety
Facing cross examination possibly by a lawyer
Writing a Medico-legal report (including what to look for and whom to consult)
Overview of the Legal System
Medical Negligence
Consent to Medical Treatment
Refusal of Medical Treatment
Confidentiality

Effective Change Management

The need for change
Psychology of resistance to change
Developing a change management plan
Communicating change
Challenges for Effective Change Management

Regulation and Policy and Standards Setting

Setting of policies and standard operating procedures
Setting of standards and measuring using KPIs
Keeping statistics that count
Maintaining Quality through measuring

Policy coordination for EU and Internal affairs
Health information for research and planning
Project implementation and monitoring
Coordination of consultation with stakeholders

Managing Resources –Finance

Why is Finance / Human Resources crucial to any organisation?
Where does Finance / HR feature in the MHEC setup?
What is the function of finance vis-à-vis internal and external clients?
What are my responsibilities as a first line manager with regards to Finance / HR

Direction and strategy

The process of formulation and implementation to create the context for growth and craft the organisation portfolio

The distinction between policy and strategy

The realities between the technical (Health) vs. political

Understand customer benefit

Facilitate to distinguish between short, medium and long term goals

Enable beneficiaries to understand organisational transformation

Enable to appreciate the importance of aligning to overall direction

Ensure that strategy is understood as a dynamic process that changes according to opportunities and learning.

Conclusion

Integrative approach and the use of Multiple Intelligences Theory

Overview of three tiered course

Motivate and Develop the **Individual** as a leader - Implementation plan

Build and Maintain the **Team** – Implementation plan

Achieve the Common **Task** – Implementation plan

Method of delivery of course

All effort is undertaken to ensure that the course is highly interactive and based on the application of theoretical concepts of leadership and management to practical situations that arise within the workplace setting. Practical exercises and case studies are used extensively.

Presentations are workshop style whereby beneficiaries access their reflective diaries and create an action plan as to how they will be realising what they have been taught within the workplace.

Didactic method of teaching is kept to a minimum to encourage participation and implementation.

Dr Paul Micallef

Dr Rita Micallef

5th September 2011

INTERVIEW SCHEDULE

Participant demographic information

Introductions, background and experience in relation to leadership in the organisation.

Profession:

Interviewees position/level:

Work situation:

Years at the hospital:

Role in the organisation:

Number of staff members responsible for:

Leadership skills training courses apart from that offered by the Ministry for Health:

Here are some questions that may help you to recall your leadership experiences in your current role.

1. How long have you been in this position?
2. I would like to know about your leadership role – can you help me understand what you do?
3. What recognises you as a leader within your profession?
(Probes: How do you define leadership? When did you start thinking of yourself as a leader?)
4. What are the most satisfying aspects of your leadership position?
(Probes: What do you enjoy most about your work? What factors help you in exercising leadership?)

The next set of questions is on leadership issues. I encourage you to narrate your experiences of leadership and to talk about issues or topics most relevant to you.

5. What in your opinion constitutes effective leadership?
(Probe: Identify leadership qualities and characteristics you consider valuable in today's healthcare setting i.e. skills, attributes and traits that lead to superior performance)

6. How do you lead others?
(Probes: Do you find yourself using conflicting and contradictory leadership characteristics depending on the outcome you'd like to see? Are you able to engage in flexibility and adaptability; and stability and control at the same time? Do you place a greater emphasis on staff members, or an emphasis on the organisation?)
7. What are the most challenging aspects of your leadership position?
(Probes: What are your challenges as a middle manager? What are the most difficult things you have had to do as part of your role? What are the main obstacles in exercising leadership? What are the things most likely to keep a leader awake at night worrying about? How do you find solutions to the problems you encounter?)
8. Have you ever sought support? How do you go about doing this?
(Even if the interviewee has not experienced problems)
9. Can you tell me about a time that made you feel proud and/or disappointed with the quality of your leadership in this hospital?

Now I would like us to talk about your experiences of leadership and training.

10. How were you prepared for your role?
11. In what way has the internal leadership and management training programme enabled you to exercise leadership differently?
(Probes: Do you have more confidence in the way you approach situations? Did the training provide tools and techniques that help you as a leader to broaden your thinking, to help you be more creative and create more value? Has the training helped you to think differently? Has the internal leadership and management training programme helped you to put into tangible practice what you have learnt to date? How?)
12. Can healthcare managers be taught how to lead effectively? Please explain.
13. What are your developmental and educational needs?
(Probe: Are there any types of situations that leadership development cannot prepare you for as a leader?)

Let us discuss how you perceive your leadership impact on quality healthcare and organisational development.

14. In your opinion, what is quality healthcare? How can one recognise quality healthcare?

15. How does your leadership contribute to quality care?
(Probe: Do you think that your leadership may improve patient care in this hospital? How?)
16. What changes have you been able to influence since being in your current position?
(Probes: Has your leadership had an impact on the development of the organisation? How do you bring about change in your organisation through your leadership activities?)
17. Can you think of a time that made you feel proud and/or disappointed with the quality of patient care in this hospital?

Concluding questions

18. That covers the things I wanted to discuss. Are there any other issues regarding leadership that you would like to discuss? Is there anything you want to add?

Appendix X: Phases of thematic analysis

Table A.1: Phases of thematic analysis (Braun and Clarke 2006, p.87).

Phase	Description of the process
1. Familiarising yourself with your data	Transcribing data, reading and re-reading the data, noting down initial ideas.
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic ‘map’ of the analysis.
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells; generating clear definitions and names for each theme.
6. Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating the analysis to the research question and literature, producing a scholarly report of the analysis.

Data corpus “refers to *all* data collected for a particular research project”, whilst data set “refers to all the data from the corpus that is being used for a particular analysis.” Data extract “refers to an individual coded chunk of data which has been identified within, and extracted from” an individual piece of collected data (Braun and Clarke 2006, p.79).

Appendix XI: Extract from an interview transcript of allied health middle manager showing initial stages of analysis – example 1

<p>VA Yes. What do you mean? How do you lead? What does it mean to lead?</p> <p>ABIGAIL It means being able to have a sense of purpose and sharing that with other people and making other people to do it themselves. Not pushing people to do. That's what leadership is okay. Leadership is about creating a vacuum in which other people grow into. You lead but you create a vacuum and people fill it. That's how I like to look at it.</p> <p>VA Right.</p> <p>ABIGAIL When you lead from in front by example alright? But what you're doing is setting a tone. You're creating a vision but I think that's an overused word okay. Mmm but you're setting a purpose and you're inspiring people. At the end of the day that's what the leader does. You need to inspire people.</p> <p>It's a cascade of and that's where the pride of leadership comes. You can never attribute, you'd like to be able to attribute all the good things to yourself but it's not like that, you know? But you know that you've been a part of it. Somewhere along the line you know that you've contributed to it. So I think that perhaps with leadership that's one of the biggest things, actually acknowledging that it is not the leader who achieves, the leader achieves through other people. That is reality. It has to be, if you are not achieving through other people, you're not leading anything. I've always looked at successful leaders as people who have got people following them with no effort whatsoever, you know? And they're doing it, not following because I don't think that following is the right word. That worries me a little bit because I don't think it's following that you want. You want your staff to be convinced. Following is not the issue so I said you lead from in front but it doesn't mean that people are following you. This thing of following doesn't sound quite right somehow. You don't want actually people to follow you; you want people to work with you. Following you? This is not the Pied Piper of Hamelin. I always imagine myself that way, that's not quite it. I don't identify with that, you know. You want people to identify with what you believe in and that is what you lead them to. To what you believe in and what is perceived to be the direction. That's the leading that you do. It's not because they follow you. For me the interpretation of leadership is a little bit different. I will lead you to, not I am leading <i>you</i>, you follow me. There's that lovely analogy to creating the vacuum and people's motivation grows into. That's what you do, you create that vacuum alright? They're not following you; they're filling in that vacuum.</p>	<p><u>Leadership</u> - interactions.</p> <p><u>Leadership</u> – giving others necessary space in which to grow.</p> <p><u>Qualities</u> – being a source of inspiration; role model.</p> <p><u>Satisfying aspect</u> – achieving through others.</p> <p><u>Emotions</u> – pride.</p> <p><u>Leadership</u> - developing performance and competency; being part of the process; achieving through others.</p> <p><u>Leadership</u> – achieving through others; people “following” you with no effort; teamwork and interpersonal relations; helping people to identify with vision and beliefs; creating a vacuum in which people's motivation grows into.</p>
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Appendix XII: Extract from an interview transcript of nurse middle manager showing initial stages of analysis – example 2

<p>VA Can you help me understand what you do?</p> <p>NADINE Do you want the truth about how I'm feeling right now? I'm feeling a disaster. I could go back to being a nursing officer. It's much more rewarding.</p> <p>VA Why are you saying so?</p> <p>NADINE As a nursing officer, I was more in control of situations. What I mean by control is that I knew what was going on; I used to keep my ward spick and span; I knew my staff members; hmm, and up to a certain extent, I was able to control the conduct of staff because you'd know what's going on all the time. It doesn't mean that monitoring and managing performance was 100% fine but now I am not even involved in the recruitment of staff. Sometimes staff with improper conduct on other wards is being dumped in the areas I'm responsible for. That's how I feel and that's what I wrote in my monthly report, because I won't transfer a member of staff who has committed mistakes in one area, to a more complex area. I'm responsible for these wards, so my areas tend to be very complex. The nurses here have to be 100% concentrated, on their toes and they have to really know what they are doing. It's offensive when a staff member who is committing mistakes on a ward is transferred to one of my wards. These issues are irritating me.</p> <p>VA Right. So what do you expect to be doing in your leadership role?</p> <p>NADINE That when I talk about these issues, they acknowledge me. For example, something else that irritates me is that my staff members go and discuss things with my superiors and my superiors believe what the staff tells them. I'm always being bypassed. This is always happening in our position. When one of the staff decides that she wants to talk to the management, they don't pass through us.</p>	<p><u>Emotions</u> –hopelessness. <u>Leadership</u> - expectations.</p> <p><u>Leadership expectations</u> - being in control.</p> <p><u>Challenging aspects</u> – not being in control; lack of participation and involvement; unable to negotiate agreement with senior management. <u>Leadership</u> – dealing with complexity; understanding staff. <u>Emotions</u> – helplessness; anger.</p> <p><u>Leadership expectations</u> - crying out for recognition and acknowledgement.</p> <p><u>Emotions</u> - Feels that she is being backstabbed; complex situation generating ill feelings.</p>
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Appendix XIII: Extract from an interview transcript of allied health middle manager showing initial stages of analysis – example 3

<p>VA Do you see any other obstacles in exercising leadership?</p> <p>AARON When our very own management does not appreciate our efforts. I do not do my work to get pats on the back. I mean if people do pat me on the back, I'd like that. But when you state that we managed to increase the number of tests in a year, doubling the number of patient tests we do in a year, I expect to get a thank you. The response is that it's like no big deal. So you start asking yourself what the efforts are for? Or else you are asked to attend for an important meeting. You are told that the requests will start coming in through a computer system and you convince your staff which won't be easy. And when you manage to get the system in place they tell you it's no big deal. Why all the effort? You don't get support from your superior. Another thing, I'm also accountable for health and safety here. There is an emergency exit door that people used to go out through when they got out to smoke. There was a report that this door was being kept open. We closed it and attached a note to it indicating that the door should not be used because it's an emergency door. When one of our top people returned from leave, he saw this note and tore it apart. He then phoned me to ask what this was all about. Then he told me that he used this door in the morning to get in to work. Don't do these things when I'm on leave because if the door is locked I won't be able to come in. I felt my legs trembling. Why am I unable to take certain decisions that I'm supposed to be taking? Why have I been put in this position? Is it because I'm capable or is it because they did not have anybody else, so they chose me? You reflect on this and you feel more stressed.</p> <p>VA And what happened then?</p> <p>AARON It was sorted out then. The engineer came into it as well and a compromise was found. I still felt that I was treated badly. There was another occasion where there was a gas leak and we had to evacuate people. It was an emergency and then I informed him afterwards. His reaction then was different. It's not consistent at all. So you start asking, how will he react today to my decisions? How do I tackle the situation so that the person does not think I'm challenging him? You're never sure.</p>	<p><u>Challenging aspect</u> – lack of support; non-appreciative management; yearns for recognition & support.</p> <p><u>Middle role</u> – squeezed in between; accommodating senior management demands. <u>Superiors</u> judged against their ability to demonstrate that they <u>care</u>; lack of <u>support</u>.</p> <p><u>Emotions</u> - made to feel that his professional opinion did not matter; feeling intimidated by superior. <u>Reflecting</u> & trying to <u>make sense</u> of his position & role; <u>challenging situation</u> precipitates <u>emotions</u> - ill-feelings, doubt & inadequacy.</p> <p>Negative <u>emotions</u> lead to ill-feelings; workplace <u>challenges</u>. <u>Senior management's</u> inconsistent behaviour reveals <u>emotions</u> - anxiousness & uncertainty.</p>
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Appendix XIV: Extract from an interview transcript of nurse middle manager showing initial stages of analysis – example 4

<p>VA Let's now talk about your experiences of leadership and training. Do you feel you were prepared for your role? How were you prepared for your role?</p> <p>NICOLE No, you're never prepared. No you're not prepared. No book or theory of leadership prepares you for the situations you encounter.</p> <p>VA I'll now ask you about the internal leadership and management training programme. Did the programme enable you to exercise leadership differently? What, if anything, do you do now that you didn't do before you participated in the programme?</p> <p>NICOLE Yes, it helped. It was an experiential programme. We had a lot of discussions.</p> <p>VA What do you mean by this?</p> <p>NICOLE Sometimes when we'd be discussing a topic, it reminded me of my own personal experiences. So it starts making more sense and you can discuss. Somebody else would have been through similar experiences, so you can share experiences. Experiences are important and so you may start putting into practice what you'd be taking in from the programme. Nobody will solve your problems but the feeling is that others have been through similar experiences and you can pick up ideas how others go about managing their own problems.</p> <p>VA Did the training provide other tools or techniques that help you as a leader?</p> <p>NICOLE Sometimes the lectures would not be so applicable, and another thing I feel is that some of the lecturers did not appear to be in touch with the difficulties within the health sector. They tell you, this is the way things should be done. Of course, we know that but in practice it does not work. In my opinion, it's not always applicable in practice.</p> <p>VA Do you think that healthcare managers can be taught how to lead effectively?</p> <p>NICOLE You learn. Life teaches you as well. People are not born leaders. There are people who are born and they walk on all fours, and there are others who are born in a royal family with a crown on their head. I do believe that you learn as you go along. And you can learn from everybody. It all depends on what you do with the knowledge you gain.</p> <p>At the end of the day, it's about our practice. Obviously we care for patients. The patient is the focus of our work. You feel satisfied when the patient has been managed and is now walking out of hospital pleased. It may be that he complains about some other things, that he was kept waiting for too long. Sometimes we don't have control over</p>	<p><u>Preparation for role</u> - did not feel prepared for workplace situations; hint of <u>complexity</u> encountered in work situations.</p> <p><u>Training</u> - relevance of <u>experiential learning</u>; interactions.</p> <p><u>Training</u> - draws on <u>others' experiences</u> and uses it for her own <u>learning and practice</u>.</p> <p><u>Training</u> not applicable to situational context; <u>difficult to apply training to practice</u>.</p> <p><u>Leadership qualities</u> - displays humility & teachableness, confidence & assuredness.</p> <p><u>Leadership qualities</u> - <u>care</u>; patient-centred. <u>Emotions</u> – pride with quality healthcare.</p>
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<p>that. But at least, just consider how many patients attend for appointments. The number is huge, you understand? And I think the fact that we manage all these people is very satisfying.</p> <p>VA We're talking about training. Do you think the internal leadership and management programme can be improved so as to suit your developmental and educational needs?</p> <p>NICOLE I suggest that we're mentored on the job. It would be excellent if you'd have someone going around with you. It's as if you'd have someone in your pocket. When you sneeze you get a tissue out of your pocket. It's not someone who tells you what to do but someone who guides you to find the right solutions. It's your role to act and to find solutions. If for example, there's somebody who'd give me all this theory, I'd want to know what he actually does in practice. What is his advice? What is his guidance? It's like having someone in your pocket.</p>	<p><u>Emotions</u> - gaining satisfaction from the care.</p> <p><u>Training need</u> - mentoring in the workplace.</p> <p><u>Mentor</u> providing feedback & advice; mentee acquiring new skills, attitudes and perspectives.</p> <p><u>Mentoring</u> - translation of theory into practice.</p>
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Appendix XV: Master list of codes

As I analysed the interview transcripts, I assigned codes to segments of the data. During coding, I developed a 'master list' so as to group the codes.

1. Leadership and experience
 - The leader
 - Satisfying aspects of leadership – proud moments
 - Challenging aspects of leadership – disappointing moments
 - The realities of middle managers
 - Support networks
 - Perception of leader by followers
2. Competing leadership values
 - The integration of opposite activities
3. Desirable leadership needs and competencies
 - Leadership qualities and characteristics leading to superior performance
 - Valued aspects of leadership
4. Training in leadership and management
 - Positive talk
 - Negative talk
 - Training needs
 - Improvement of training programme
5. Quality healthcare
 - Leadership contribution to quality healthcare
 - Leadership impact on organisation
 - Proud moments
 - Disappointing moments

Each element within the 'master list' actually grouped a number of sub-codes derived from the raw data. So as to give some examples for 'The leader':

- Paradox of trust and vulnerability
- Hard worker
- Expects the best
- Clear communication
- Maintaining the balance
- Challenging the status quo
- Leading change
- Focus on team interests and needs
- Good example
- Vision
- Care
- Moral courage
- Recognition.

Appendix XVI: Themes and sub-themes related to the concepts within the theoretical model used in the research study

Table A.2: Theme one – middle managers’ leadership perceptions and sub-themes.

Middle Managers’ Leadership Perceptions	Leadership Perceptions	1. Meaning of leadership
		2. Leadership qualities
		3. Factors promoting and hindering leadership practice
		4. Range of emotions

Table A.3: Theme two –organisational challenges and sub-themes.

Healthcare Context	Organisational Challenges inherent within the healthcare context	1. Caught in the middle
		2. Leadership impact
		3. Dealing with challenges
		4. Support and hindrances
		5. Quality care and delivery

Table A.4: Theme three – leadership training and development, and sub-themes.

Middle Managers’ Training and Leadership Development Needs	Leadership Training and Development	1. Preparation for role
		2. Outcome of training
		3. Leadership development needs

Appendix XVII: Sample description of themes, significant quotes and their meanings, from which findings were derived

Leadership Perceptions	
<u>Significant Quote</u>	<u>Interpretative Statement</u>
<p>“I was at a cross road whether I should resign because I had my superiors completely against me. Hmm, I hadn’t done anything wrong. I had applied for a promotion and according to them I shouldn’t have applied. It was something personal but they took it really badly. I asked for mediation and they did it. But it took me two weeks of crying every day...I was desperate. Can you imagine going to meetings and they don’t talk to you? Or they point fingers? It was just terrible. I think it was the worst time of my life, I think.”</p>	<p>Nadia revealed the lack of support and resistance experienced by senior management. The situation aroused a number of negative emotions. She described and interpreted these emotions through strong and uncomfortable feelings.</p>
<p>“Proud is when I am supported by my superior and things have moved, for example, improvement in services, the possibility of providing more courses and training for my staff. Although several initiatives haven’t gone through his support and were stopped, he had other initiatives which were good and we went along very well with it. The only thing is that he involved me in them. I feel good about it but I wish it would be so much more.”</p>	<p>Alan voiced that the dynamics of his everyday work realities were very much linked with the support of his superior or lack of it. When he felt that his experience and expertise were being valued, he experienced positive emotions that promoted feelings of self-worth.</p>
<p>“I am proud when the patients are being given the right care. I feel proud that I made a difference by transmitting the right messages to staff.”</p>	<p>Nadine revealed positive emotions, namely, caring and compassion. This was associated with the provision of quality care to patients and managing staff performance.</p>
<p>“The main obstacles I find are those concerning people, cooperation. It puts me down a lot. It tests my skills, yes. It tests me a lot.”</p>	<p>Anthony revealed emotional dilemmas in dealing appropriately with staff members. Dealing with the human aspect evoked challenging emotions.</p>

Organisational Challenges	
<u>Significant Quote</u>	<u>Interpretative Statement</u>
<p>“I opt to be sincere with staff members. I do say that this is the way that my superiors are seeing this and that they may be seeing a larger picture to the one I’m seeing...then I get really frustrated when they do not know the big picture...But then I won’t pass on my disappointment to staff members. You’ll have to carry that.”</p>	<p>Anna highlighted her experience of being caught in between senior management and staff members. She explained how she sheltered her staff from the tensions she experienced.</p>
<p>“When new nurses were recruited, I went to the wards and I just found them there...I didn’t even know about them...I feel that this is an obstacle. It’s an obstacle for exercising leadership. We have to work in these conditions and you try your best under the circumstances. So then you try to lick your own wounds because this really affects me and you try to move on. At the end of the day, we have the new nurses. It doesn’t matter how I got to know about their recruitment.”</p>	<p>Natasha conveyed the conflicts and dilemmas she experienced. She sought balance in a conflicting situation in order to maintain operational continuity. Natasha preferred to see the possibilities rather than the problems and adopted a non-confrontational attitude.</p>
<p>“I feel like a sandwich between the higher management and staff on the wards...Before, I used to take the decisions myself, different types of decisions. But now it’s really difficult...And then the job is what you make it so you try to see what needs to be done.”</p>	<p>Naomi reaffirmed middle managers’ paradoxical position. Despite feeling overwhelmed by the situation, she managed to rise above this.</p>
<p>“You’d have an objective and you’d have to get there using your experience and judgement. Yes, sometimes it may be that you’d have to sacrifice control at the expense of flexibility...You can’t be flexible all the time. You can’t be in control all the time. There are the grey areas and I think that as managers we work a lot in these grey areas.”</p>	<p>Abraham reflected on his responsibility to perform contradictory roles, thus experiencing leadership as the integration of positive opposites.</p>

Leadership Training and Development	
<u>Significant Quote</u>	<u>Interpretative Statement</u>
“Definitely we need more training...there needs to be a balance between theory and practice because it’s futile if I sit there and listen and then cannot apply it in practice.”	Amber indicated that there should be alternative approaches to leadership training where the leadership theory may be applied in the workplace realities.
“No, I was definitely not prepared. I had to adjust and go around and ask. I had to learn a lot. It was a learning experience but it can destroy the person. I felt that a lot.”	Nancy’s strong and meaningful statement suggested the lack of training in preparation for her role.
“There should be a mentor, a person whom you need in practice, with whom you may discuss there and then.”	Adam proposed that mentoring could help improve his practice during his everyday working realities.
“The fact that we used to meet during training and there was that forum element, <i>that</i> helped me...you identify with people, with people who’ll be reflecting, talking about their own experiences, what they’ve been through. You identify with them. You get to know them and you know that on the basis of that collegiality, you can approach that person for support and guidance. It’s a way of exercising leadership differently.”	Arthur felt that the sharing of experiences, challenges and solutions generated by other’s professional roles during the training programme provided him with a support safety network. Networking also supported his need for collegiality and promoted feelings of self-worth, autonomy and control.